

**HOW DO GENERAL PRACTITIONERS EXPERIENCE
SATISFACTION WITH THEIR CONSULTATIONS?**

A qualitative study

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Declaration

I declare that the work reported in this thesis was conceived and conducted by myself, and that the thesis was composed by myself. None of the contents have been used in support of another degree or professional qualification.

Signed

Date 12th September 03

Acknowledgements

Although this thesis is my own work, it would be remiss of me not to acknowledge the help I have received from others.

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ABSTRACT

The consultation between an individual patient and doctor is the bedrock of general medical practice. Varying perspectives on the nature and purpose of this interaction are apparent in the writings about the general practice consultation over the last half-century. The view of the consultation that underlies this study is that it is a social act whose nature and characteristics are determined in interaction between the doctor and patient and not by the activities of the doctor alone. The aim of this study is to explore how general practitioners experience satisfaction with their everyday consultations.

Nineteen general practitioners took part in the study. They each audio-tape recorded between 25 and 30 consultations with consecutive consenting patients. They scored each consultation according to how satisfying they found it on a scale of 0-10, where 0 was maximally dissatisfying and 10 was maximally satisfying. A sample of six consultations from each doctor were chosen to include the most and least satisfying and these formed the basis of an in-depth qualitative interview between the doctor and myself. The data from the interviews was analysed using constant comparison to elucidate the doctors' views about their consultations and the reasons for consultations being satisfying or not.

The empirical findings of this study reveal that the way doctors experience satisfaction in consultations relates to four broad issues. First their evaluation of their technical performance in the consultation, in particular their deployment of their clinical skills and their communication skills. Second the way they morally evaluate the patient and the purpose of this evaluation in the conduct of the consultation. Third the sense they have of knowing the patient which is seen to be qualitatively different from their knowledge about the patient. And finally the sense

that the experience of the consultation is congruent with their knowledge of themselves as a doctor and thus is implicated in them maintaining a positive self-identity.

On the basis of these empirical findings a loose conceptual model of how general practitioners experience satisfaction in their work is proposed. The findings of the study are seen to have implications for the organisation and delivery of primary medical care, for the training of doctors and general practitioners and for the conduct of general practice research.

CHAPTER 1: INTRODUCTION

“The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it”¹

The purpose of this introductory chapter is twofold. First to outline the arguments for pursuing the investigation of general practitioners’ satisfaction with their consultations upon which this thesis is based, and second to provide an overview of the structure of the thesis that follows.

General Practice in the NHS

In continuing debates about the future of the National Health Service in the United Kingdom, there seems little contention that primary care should lie at its heart. Furthermore general practice remains the core business of primary care despite the organisational shift away from general medical practice to primary health care that has occurred over the last 30 years. General practice is still perceived to encourage continuity of care for patients, and a family and population approach to health care, and to ensure direct and universal access to primary care services for the whole population. Morale among general practitioners however is reported to be low and recruiting and retaining practitioners is a major concern for policy makers and the profession alike^{2;3}. Thus it seems the apparent value placed on primary care and general practice in the development of health services is not reflected in an engaged and satisfied profession.

Indeed at the same time as changes in the organisation of primary care have been occurring, the external expectations of doctors have burgeoned. Doctors are now

expected to not only provide high quality medical care, but also promote health, educate patients, collaborate with other health and social care professionals, plan for the development of their practice and their locality, involve patients in this planning, and address the public health needs of the population. Moreover doctors are expected increasingly to be accountable for their actions in these areas. Whilst doctors rail against these expectations often seeing them as unrealistic and utopian, they, at the same time, internalise them. It has been suggested that one reason for doctors being unhappy in their work is dissonance between the characteristics and external expectations of their job and their own job aspirations⁴.

Despite newer demands upon general practitioners the consultation with an individual patient remains the bedrock of their work. However co-incident with changes in both the organisation and structure of general practice and the expectations of doctors, the identity of the patient has also been changing. Defining the patient as more than the passive recipient of health care has been central to health policy since the late 1970's. This re-interpretation of the patient reflects wider political and cultural changes as much as the manifesto of any political party. The patient is now encouraged to regard themselves not only as a patient but also as a consumer and, to some degree, as an adjudicator on the quality of service and care they receive. A succession of studies have explored patients' views on their interactions within the health service⁵⁻⁷ and measures of patients' satisfaction with specific interactions⁸ and with the service more generally have been developed⁹.

The consultation in general practice

In the context of general practice, attempts to understand patients' views have focussed on the consultation as the point at which "quality" is assessed. Indeed the consultation between a doctor and an individual patient is absolutely fundamental to general medical practice. More than one million consultations take place every day in general practice in the UK. The general practice consultation has myriad therapeutic possibilities and, as a professional group, general practitioners have become acutely aware of the extent to which the quality of the consultation correlates with the quality of care provided by the doctor. This is reflected in the emergence of a relatively large body of research and educational literature, reviewed in this thesis in chapter 2, describing and evaluating the quality of the activities that take place in the consultation. Whilst the evident shift in the political identity of the patient over the last two to three decades may be seen as a welcome redress for past paternalism, it has also had the, perhaps unintended, consequence of marginalising the doctors' perspective on what is valuable in this interaction. Furthermore a model of patient satisfaction in which satisfaction is defined in relation to a clearly identifiable group of variables may in fact be quite disabling for doctors. For it may enforce quite impermeable boundaries within which they feel it is acceptable to express their own satisfaction or dissatisfaction with the consultation. Disentangling those qualitative or contextual features of the doctor's activities that add value to the interaction becomes steadily more difficult. Concern about this marginalisation of the doctors' view may seem largely misplaced in the current climate where the patients' views of their care are seen as pre-eminent and the political imperatives are around placing the concerns of the patient at the centre of healthcare. However the doctor also invests greatly in the consultation and his or her views may not always coincide with the patient's views. The impact of such disagreement may not only lead to frustration for the doctor in the individual consultation but cumulatively cultivate stress and disaffection which

is likely to have long term consequences for the quality of health care delivered and for the health and wellbeing of the practitioner. Furthermore what is valuable about the consultation may be hidden from the patient, and it may not always be necessary or desirable for the doctor to make explicit to the patient the nature of his or her contribution to the continuing interaction between them.

The current study

Whilst there is a large body of research directed at measuring patient satisfaction with medical care, relatively little research has sought to investigate directly the satisfaction of doctors with their work. In consequence we do not understand well doctors' criteria for satisfaction with a consultation. In particular what is missing from current understanding of satisfaction with consultations is any grasp on its moral qualities. These are difficult to define, for they are often contingent or situational, and they are certainly hard to quantify for external observation. The research agenda around satisfaction with the consultation needs to take account of the doctor's view in a way that recognises that he or she also invests greatly in the consultation.

Therefore this study investigates present day general practitioners' satisfaction with their routine consultations. It explores how they experience satisfaction (or not) by examining the meaning their consultations have for them. The rationale for the study is underpinned by a belief that it is not possible for doctors to be clinically dispassionate about their work, and that their experience inevitably engages their feelings as well as their intellect. It therefore seeks to understand the way in which doctors make sense of what occurs in these encounters by examining their emotive responses to interactions.

This thesis involves the application of some sociological ideas to general medical practice but it is not medical sociology. It is intended first and foremost to contribute to the debate about the consultation in general practice and to do so from the perspective of the experiencing general practitioner.

Overview of thesis

The overall structure of the thesis is as follows.

In chapter 2 the literature about the general practice consultation is reviewed. Three perspectives on the general practice consultation are identified within the empirical literature. One that views the consultation as a technical problem of practice for the doctor. A second that is concerned with the issue of patient-centredness and its expression within the consultation, and a third which sees the consultation as a moral encounter in which both doctor and patient are experiencing individuals.

Chapter 3 outlines the theoretical issues and methodological considerations that underlie the eventual choices I made in the conduct of the study. In particular the tenets of social constructionism and its proponents' views on the nature of social reality are considered in relation to the nature of the general practice consultation. The way the study was conducted in practice is described in detail including reflection upon the difficulties I encountered and the compromises I eventually made.

Chapters 4,5,6 and 7 present the empirical findings of the study. The analysis presented here is intended to go beyond description into interpretation of the way doctors experience satisfaction with their consultations.

In the final chapter, chapter 8, the empirical findings of the study are drawn together and a loose conceptual model of how general practitioners experience satisfaction with their work is presented. The implications of the study and its findings are discussed in relation to the development of primary health care services, the future of the discipline of general practice, the nature of medical education and the conduct of primary care research.

CHAPTER 2: BACKGROUND AND SELECTIVE LITERATURE REVIEW

Introduction

The general practice consultation is a particular form of medical encounter. For the most part it constitutes an interaction between a doctor and a single patient. Each general practice consultation in the United Kingdom occurs within a particular context configured not only by the way the National Health Service is organised and the place of general practice within it but also by the nature of the relationship between the individual doctor and patient. The extent of writing about the doctor-patient interaction in the medical encounter means that it is not possible to review all the literature in this field systematically or comprehensively. Neither given the novel nature of the study that follows is it necessarily crucial to do so.

This study is rooted in general practice, and therefore in this chapter I will be particularly, but not exclusively, concerned with writings about the nature of general medical practice and the general practice consultation. The literature chosen exemplifies the formulation and reformulation of the doctor-patient relationship in general practice over the last 40 to 50 years as this reflects the changing nature of general medical practice during the same period. The point of this chapter is to connect the work already published with that which follows, and in so doing to provide a rationale for the study and for the methodological approach chosen.

Perspectives on the general practice consultation.

Reflection upon the conceptual and empirical literature about the general practice consultation of the last 50 years reveals three broad perspectives on the interaction.

- One that regards the consultation as a *technical problem of practice* for the doctor, and which is therefore primarily concerned with issues of efficiency and good practice.
- A second which is concerned with the ideology of *patient-centredness* and the consultation as the medium for its expression.
- And a third that considers the general practice consultation as a *moral encounter*, and is concerned with the characteristics of an interpersonal act between doctor and patient in which the patient is seen as an experiencing individual and not the organic object of medical attention, and the doctor as more than the embodiment of medical knowledge and technical skills.

As I go on to describe and discuss this literature it will become apparent that these perspectives emulate views about the nature and purpose of general practice as a whole: views which are in fact not mutually exclusive. Consequently although the literature is presented here in quite distinct sections, reflecting these perspectives on the consultation, there is in fact significant overlap between the sections. Indeed much of the literature is congruent with more than one of the perspectives and therefore appears more than once in the review.

The next section discusses the genesis of these perspectives, by way of very brief reference to the history of the subjective patient and to the history of the discipline of general practice.

How did these perspectives arise?

Something of the origins of all three perspectives, but particularly the second and third themes can be traced in the history of the “patient as person”. Armstrong¹⁰ and May¹¹ both outline how the subjectivity of the patient, presumed to have been present and important in 18th century medical practice, was suppressed, at least in the literature, by the emergence of “scientific medicine” in the 19th century. At this time diseases were first recognised as objective pathological phenomena occurring within the tissues of the body, and patients became the passive objects of clinical knowledge and expertise.

Armstrong goes on to describe how the subjectivity of the patient re-emerged in the inter-war years of the 20th century. He takes the literature around venereal disease, defaulting and non-compliance to illustrate how the patient became imbued with personal qualities. He relates how patients moved from being docile carriers of disease, in his example venereal disease, to become problematic in their own right as potential defaulters from treatment. Thus the patient was recognised as more than a passive conforming object but as an individual with a will of his own whose motivations and cognitive processes were instrumental in their health and illness. As May¹¹ points out this opens the way for the discipline of psychology to be drawn upon to re-define the doctor-patient relationship and for the patient to be seen as a moral actor in this interaction.

Later the doctor-patient relationship, as opposed to the patient alone, was seen as the site of problems. Patients were seen to be non-compliant not because of any inherent deviancy but because of miscommunication between doctor and patient. It will be seen later how the problems of communication evident in the doctor-patient relationship came to be decisive in establishing a rationale for the discipline of general practice.

The disciplines of general practice and medical sociology

At this point sociological interest in medicine and in particular the doctor-patient relationship accelerated. It is not my intention to discuss extensively the medical sociological literature in this area here for it is vast and much of it has only tangential relevance to general practice and the question under investigation. However there is little doubt that medical sociological thought has been influential in the development of the discipline of general practice and in particular its ideas about the consultation and therefore it is important to consider some of its main concerns here.

In its early days, partly to set its own intellectual agenda, medical sociology differentiated between disease and illness. To do so it separated the natural and biological, which included those pathologies known as disease, from the cultural meanings and social understandings of illness. Thus illness became seen as disease plus meaning and, unlike disease which was invariant, susceptible to historical, cultural and situational variation. Identification of the concept of health and illness behaviour followed. First proposed by Mechanic in 1961 the concept of illness behaviour¹² not only recognises that symptoms might be perceived differentially by different people but also that people of different cultures or living in different circumstances might evaluate and act upon them differently. He suggested that the concept of illness behaviour might explain why and how patients decide to consult a doctor. Furthermore this decision to consult is a pre-condition for doctor action and directly influences whether a diagnosis is made at all, or a disease label is applied, and whether treatment is initiated. As a concept illness behaviour therefore bridges the gap between health and illness and blurs the boundary between person and patient. In other words, whether or not a person becomes a patient when experiencing symptoms is dependent upon a variety of social and personal factors. In the seminal paper "Pathways to the doctor" Irving

Zola¹³ sought to disentangle the reasons why an individual might seek medical help. His findings confirmed the inadequacy of the scientific/biological model of medicine and medical practice. His formulation drew attention to the wide array of beliefs and practices that patients hold about their physical and mental wellbeing and has been influential in the development of the concept of patient-centredness to which I will return later. It also led to recognition that patients are far from passive but rather engage in meaningful social action by which they manage their health and illness.

An alternative view of the agency of patients was proposed by the American sociologist Talcot Parsons¹⁴. In 1951 he published a model of the duties and rights of patients. He suggested that adopting the "sick role" was legitimate as long as patients seek medical help, follow medical advice, and actively seek to become healthy again. He saw the doctor as the arbiter of the genuineness of the patient's claim to illness. The asymmetry in the relationship between doctor and patient this model infers is obvious. The doctor is active and authoritative and the patient passive and submissive.

The separation of disease from illness, the natural from the cultural re-enforces the division between the lay and professional perspective that is an important device in medical sociology. The medical encounter occurs at the intersection of these perspectives and the social scientific literature is replete with data and interpretation concerning doctor-patient interaction in the medical encounter. The majority of this is derived in settings other than primary care or general practice, however many of the features of doctor-patient interaction identified have informed subsequent analyses of interactions in the primary care setting. Many medical sociologists have examined the way in which the medical encounter is accomplished by its participants. The essentially asymmetric nature of any

collaboration between doctor and patient - the patient is lay and the doctor expert - has been central to their analyses. This standpoint leads to an exploration of doctor-patient interaction that favours issues of authority, control and powerⁱ and sees the smooth accomplishment of medical consultations as a result of doctors' coercive control over the form and content of talk in the interaction. In contrast the patient is seen as powerless, subjecting their medical problem to the objectifying gaze of the doctor. In essence through interpersonal communicative techniques and negotiation the patient's personhood is transformed into the doctor's case.

An alternative less conspiratorial view of power in medical encounters transpired through the 1970's. Freidson¹⁵ writing in the early 1970's identified potential conflicts in the doctor-patient relationship. He denied that the patient was always passive, indeed he believed that the patient was often active in the doctor - patient relationship. He sparked new interest in, and respect for, the patient's depiction of their situation and how this might vary from the authoritative accounts of doctors. Stimson and Webb¹⁶, writing about general practice consultations, also saw the consultation as a site of power negotiations in which "both sides attempt to direct and control the outcome of the consultation to their own ends: the outcome depends not only on the nature of medical complaint but also on the nature of the negotiations". However in their account the encounter was the arena for subtle negotiations between doctor and patient rather than the site of overt conflict. The rarity of outright conflict in doctor-patient interaction was confirmed in Strong's "Ceremonial Order of the Clinic"¹⁷. Hence an alternative view of medical encounters

ⁱ Here the concept of power is a traditional sociological one in which power is seen as an entity which resides in or with one person and is used to subjugate another. Alternative interpretations of power, such as Foucauldian approaches, see power as a form of social organisation.

in which both doctor and patient, rather than the doctor alone, were seen to contribute to the outcome of the consultation materialised.

So to summarise, I have shown how the re-emergence of the patient as an experiencing individual occurred at the juxtaposition of historical trends in the practice of medicine and developments in the rapidly evolving field of medical sociology.

Development of discipline of general practice

The re-emergence of the patient as an experiencing individual was crucial to the development of the nascent discipline of general practice, providing a way for it to differentiate itself from specialised hospital medicine. Whilst the latter continued to privilege the biomedical aspects of disease in the treatment of illness, general practice and general practitioners began to recognise the interconnections between the physical, psychological and social aspects of their patients' ill-health. The work of Michael Balint in the 1950's was particularly significant in elucidating the importance of these patient factors in constructing and analysing consultations¹⁸. A new concept - "whole person medicine" - emerged. This new concept began to help address the challenge laid down in the Collings report in 1950 "to decide what the general practitioner should be doing and then - whatever it is - enable him to do it properly"¹⁹. The Royal College of General Practitioners (RCGP) newly formed in 1952, a few years after the inception of the National Health Service and soon after the publication of the Collings report, wholeheartedly endorsed whole person medicine, as a defining feature for their discipline.

In "The Future General Practitioner"²⁰ an RCGP working party proposed the following job definition.

"The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting room or sometimes in hospital. He accepts the responsibility for making an initial decision on *every* problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate where necessary. His diagnoses will be comprised in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health."

This definition was somewhat controversial because it presented a new vision of what was possible and imposed new parameters for the definition of high quality care. It alluded to five areas that were considered likely to typify the work of the practitioner of the future: health and diseases; human development; human behaviour; medicine and society; and the practice. It also re-iterated the biopsychosocial basis of general practice.

A similar definition was produced two years later by the Leeuwenhorst Working Party of European General Practitioners²¹.

"The general practitioner is a licensed medical graduate who gives care to individuals irrespective of age, sex and illness. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological and social factors in his considerations about health and illness. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practice in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community."

These definitions influenced a subsequent statement from WONCAⁱⁱ about the role of the general practitioner/family physician in health care systems worldwide²² and informed the contemporary debate about teamwork in primary health care^{23 24}.

More recent definitions of the core activities and values of general medical practice as a discipline adopt a somewhat less paternalistic tone than these earlier definitions. Emphasis is now placed on the role of the general practitioner as a member of the primary care team rather than as an autonomous practitioner, and as a facilitator of patient autonomy and choice^{25;26}. The evolution of definitions of the nature of general practice and the work of its practitioners reflects the changing context within which primary care has been delivered over the last 30 years. Nevertheless the acceptance that all facets of human life are the legitimate concern of general practitioners so long as they are presented as a problem by the patient is the salient feature of all these definitions. However the essential generalism (physical, psychological and social) inherent in these definitions presents a quandary in terms of evaluating the care provided in general practice. The motive underlying the literature concerning issues of efficiency and good practice can be found in the need for general practice as a discipline not only to define clearly its content and boundaries but also to evaluate the quality of care delivered. As general practitioners routinely rely on conversation rather than complex technologies for diagnosis and treatment, the consultation lies at the core of their activities and is the site at which general practitioners deploy their particular expertise. Hence, not surprisingly, the consultation is the subject of technical evaluative frameworks for care delivered in general practice.

ⁱⁱ World Organisation of National Colleges, Academies and Academic Associations of General Practitioners / Family Physicians.

The consultation as a technical problem of practice

Defining the content of consultations

Interest in the applicability of a conceptual model, which regards primary care as biopsychosocial or comprehensive, to everyday general practice led Stott and Davis to outline a framework for each consultation which delineated its exceptional potential in terms of its content²⁷. The four possible components of a consultation were detailed as management of the presenting complaint, management of continuing problems, opportunistic health promotion and modification of help seeking behaviour. The authors indicated how doctors might use this theoretical framework to guide their potential actions in individual consultations and hence move towards bridging the gap between the theory of general practice embodied in the descriptive literature and its application in their day to day work.

Time and the consultation

One upshot of this framework was that it provided a succinct and practical way of encapsulating the content of "good primary care". Such definitions proved crucial both in the drive to improve standards of care in general practice, endorsed by the Royal College of General Practitioners and politicised by the government towards the end of the 1980's, and also in facilitating research around the quality of care in individual consultations. Lack of time in consultations – the average length of a general practice consultation in the UK in the 1970's and 1980's was between 5.5 and 6.6 minutes - was perceived to be a barrier to improving quality of care. This was not a novel notion. As Wilson points out in his review of consultation length in general practice, concern about the brevity of the typical general practice

consultation has been documented throughout the 20th century²⁸. Buchan and Richardson, whose observational study conducted in Aberdeen included 22 doctors and over 2000 consultations, concluded in the early 1970's that a ten-minute appointment system was a priority for British general practice²⁹. Researchers set about exploring and explaining how time constraint in the consultation influenced the nature of the consultation. In an observational study comparing the outcomes of consultations in two group practices offering consultations of different lengths, fewer prescriptions were issued, and fewer patients returned for follow up within 4 weeks of presenting with an acute illness in the practice with longer appointments³⁰. However the potential influence of confounding variables, including the doctor himself, presented difficulties interpreting the findings of this and other observational studies³¹. As a result researchers moved on to undertake interventional or controlled studies to investigate the effect of consultation length on the nature of consultations.

Evaluating the content of consultations

Two interventional studies both of similar design compared the content of consultations booked at different intervals. In their study of the "five minute" consultation Morrell and his colleagues³² compared the clinical content of consultations booked at 5 minute, 7.5 minute and 10 minute intervals, whereas Ridsdale and her colleagues³³ looked at consultations booked at 5 minute, 10 minute and 15 minute intervals. In both studies doctors in effect acted as their own controls, conducting consultations booked at each of these intervals, in an attempt to eliminate the confounding effect of the characteristics of the doctor on the nature of the consultation. A number of hypotheses were tested about the extent to which particular types of activity occurred in consultations of different lengths. As expected the median length of consultations booked at shorter

intervals was less than those booked at longer intervals, although the difference in actual length of consultations was less than the difference in booking intervals. Findings were not invariably consistent across the two studies, however in both studies doctors spent more time explaining the patient's problem and explaining the proposed management in longer consultations. Morrell's study found the shorter the booking interval the fewer the problems identified in the consultation, including psychosocial problems, and the less preventive activity occurred. These findings were not replicated in Ridsdale's study where overall the consultations were longer. Nevertheless communicative practices instrumental in opportunistic health promotion and modification of help seeking behaviour seemed to occur more commonly in longer consultations.

One problem with the foregoing studies is that they describe how doctors behave when asked to conduct consultations at an unaccustomed pace. As the doctors were not blind to this requirement interpretation of the findings of the studies is difficult. Howie et al³⁴ sought to identify differences in the content of consultations of short, medium or long duration occurring naturally within the normal working patterns of doctors. Irrespective of the pace at which doctors consulted naturally, they were more likely both to recognise and to deal with relevant psychosocial problems and long term health problems, and to perform more health promotion in longer consultations. In a recent systematic review of the influence of consultation length Wilson also concluded that doctors who spend more time with patients are more likely than others to have consultations that cover wider patient care agendas³⁵. Thus short consultations seem to militate against the type of "comprehensive" approach to general practice envisioned by professional leaders and academics.

Process and outcome evaluation in consultations

For this reason Howie et al proposed that the length of a consultation could legitimately be used as an indirect global measure of the quality of the consultation. However analysis of the content of consultations does not assess the effectiveness of the processes within it, irrespective of whether these processes are clinical or interpersonal. Interest in the way in which the activities of the consultation were accomplished, rather than what activities occurred, led to studies investigating the impact of general practitioners' style in the consultation.

a) Style of consulting

Savage and Armstrong³⁶ took the approach of a single doctor randomly adopting either a sharing or directing consulting style part way through a consultation to explore the effect of consulting style in the part of the consultation concerned with giving information (advice, treatment or prognosis). A sharing style was considered one in which the patient was involved in the decision-making process, a directing style one in which the doctor invoked an authoritarian and paternalistic approach. Their outcome measures were the patient's satisfaction with the general practitioner's perceived understanding of their problem and the explanation they received, and whether they felt they had been helped immediately after the consultation and one week later. A significantly higher proportion of the patients who had received the directing style felt that they had received an excellent explanation, and believed the doctor had a thorough understanding of their problem. This finding was especially true for patients who rarely attended surgery, patients who the doctor considered had a physical problem, patients who were not investigated and patients who received a prescription.

Thomas³⁷ also explored the effect of style in the advice giving part of a consultation. Two hundred patients who presented with symptoms but no physical signs and in whom no definite diagnosis could be made were randomly allocated to receive one of four styles of consultation. Two styles of consultation were termed "positive" in that the patient was given a definite diagnosis and told they would be better in a few days. In half of these consultations the patient was given a placebo treatment and assured this would make him better, in the other half the patient was given no prescription but assured he needed none. Two styles of consultation were termed "negative". In these no firm assurances were given and the doctor stated "I cannot be certain what is the matter with you". Half the patients received no prescription, the other half received a placebo prescription but were told the treatment may not help.

Receiving a prescription or not made no difference to the outcome of the consultation as measured by patient satisfaction immediately after the consultation, and speed of resolution of symptoms. Patients who received a positive consultation were significantly more satisfied after the consultation and more likely to have got better after two weeks.

Both these studies adopted an interventionist approach to investigating the effect of the processes within consultations and have been criticised as contrived. The benefits of adopting a particular consulting style suggested by the results of these two studies may well be spurious. In both cases the doctors were required to consult in predetermined and extreme ways, and the doctors were regarded as embodiments of consulting style rather than as experiencing individuals. We know nothing of the usual consulting style of these doctors and can only hypothesise about the effect of them consulting in an alien manner. Thus to extrapolate from these results to the generality of consultations occurring in general practice would

be unwise. Furthermore, in neither case is the nature of the style adopted made explicit. That is, how the doctor was actually behaving when he was reportedly adopting a sharing or a directing style, or a positive or negative style is not clear.

Huygen and colleagues³⁸ made a further attempt to explore the effect of doctor style on the consultation. They determined practitioner style by observing practitioners in their surgeries and examining their prescribing and referral rates, before examining the relationship between consulting style and the health status of their patients. Three styles of practice were distinguished.

- Integrated style: in which practitioners scored highly on measures of patient and goal orientated behaviour and performed mostly necessary diagnostic activities. Referrals were kept to a minimum as was prescribing of non-specific medicines.
- Interventionist style: in which practitioners gained intermediate scores on patient and goal orientated approaches and did many necessary but also superfluous diagnostic activities. They referred frequently and prescribed much non-specific medication.
- Minimal diagnostic style: in which practitioners scored lowly on patient and goal orientated behaviour. Few diagnostic activities were performed but referral was frequent, as was prescription of non-specific medication.

A random sample of 20 women between 50 and 65 years of age who had been on the list of their general practitioner for at least 5 years was taken from 75 practitioners' lists. Patients of practitioners with an integrated style of practice were identified as having better health outcomes. They had a better subjective sense of wellbeing, better objective health (less heart failure and chronic bronchitis), were less likely to have had a hysterectomy for non-oncological reasons, attended their general practitioner less frequently, and had more realistic

expectations of the efficacy of self care when compared to patients of practitioners with other styles.

b) Outcome of consultations

It is clear from the above that the effectiveness of particular consulting styles and the clinical and interpersonal processes within consultations is difficult to measure directly. This difficulty is due not only to problems in defining style and outcome, but also to the complexity of inputs into the consultation process. These include the diversity and range of patients' needs, the undifferentiated nature of patients' symptoms and the psychosocial milieu of their problems. As a result outcomes are likely to be context specific for each individual patient because the configuration of needs (physical, psycho-social, spiritual, health promotional, educational) and expectations is unique to each patient. Consequently evaluation by patients has developed as the prevailing approach to outcome measurement in general practice. Patient satisfaction^{8;39} and patient enablement⁴⁰ are two such approaches. This represents an important landmark in charting the path of the doctor-patient relationship in general practice for it links doctor focussed technical activities with concern for the primacy of the individual patient's view. Satisfaction is the patient's assessment of the doctor's performance and arguments abound about the extent to which patients can meaningfully evaluate care. Enablement arguably goes beyond satisfaction in that it asks patients to make judgements about the impact of the consultation upon their global health status by asking about changes in their capabilities after the consultation, for example if they feel better able to cope with life, understand their illness, cope with their illness, and keep themselves healthy. Outcome, as measured by enablement score, has been closely correlated with duration of consultation and knowing the doctor well⁴¹ and, in a study in a homeopathic hospital setting, with empathy as perceived by the patient⁴².

Models of the consultation

Patients' attitudes to their care cannot be separated from nor properly understood without reference to the experiences with which they are connected. Hence the interpersonal aspects of care, that is the way in which care is delivered, are important components of quality in the consultation. A strand of work evolved, in parallel with the work about the content and outcome of consultations, whose purpose was to describe and prescribe the way in which doctors carry out the activities of a consultation. Models that sought to encapsulate ideal doctor-patient interaction by detailing a series of tasks, to be achieved in the communication, resulted. These were also informed by social scientists' explorations of lay perspectives on health, illness and disease which demonstrate that patients bring idiosyncratic and often intensely personal experience, understanding and health beliefs into the consultation. These are often at variance with conventional medical wisdom and can lead to misunderstandings between doctor and patient if they are not explicitly sought and recognised.

The first of a small number of seminal works in this area was Byrne and Long's "Doctors Talking to Patients" published in 1976⁴³. This reported the analysis of some 2,500 audio-tape recorded consultations volunteered by just over 100 doctors from the UK, Holland, Ireland, New Zealand and Australia. Through identification of patterns of behaviour common to consultations from different doctors an ideal sequence of events was defined. This formed the basis of a theoretical model of the consultation comprising six phases including establishing a relationship with the patient, discovering the reason for the patient's attendance, examining the patient, considering the problem, detailing treatment or further investigation, and terminating the consultation. On the basis of the observed interaction between doctor and patient, Byrne and Long categorised some consultations as patient-centred, as opposed to doctor-centred, yet their model

failed to address the patient's agenda in anything more than the most superficial of terms.

The concept of the consultation as the site of negotiation between doctor and patient was cemented by the work of Pendleton and his colleagues⁴⁴. They acknowledged that patients as well as doctors bring intentions and beliefs into the consultation. The model of the consultation they proposed explicitly included identifying a patient's ideas, concerns and expectations and using this knowledge to negotiate treatment or further investigation. Tuckett and his colleagues⁴⁵ subscribed to the developing consensus that the consultation should be an interaction in which the intentions and beliefs of both participants should be recognised. However in their study of sharing ideas in medical consultations it became clear that doctors did not routinely tap into lay cognition in this way. Whilst doctors usually spent some time sharing what they thought about the patient's problem with the patient, they rarely spent much time trying to share what the patients themselves thought. Patients were helped infrequently to make clear their own theories by their doctors, and therefore could not receive from their doctors explanations that were truly reactive to them. In practice, patients were not treated as competent "experts" in their own health care and their ideas tended to be de-valued.

The undifferentiated nature of problems presented in consultations means it is necessary for the doctor to engage in a process that defines the problem or problems with which to help. One focus of models of the consultation was to re-assemble or reconstitute the patient as a human subject to allow the doctor to make sense of the patient as an actor by rationalising her social history and personality.

Communication as the technology of the consultation

This lack of correspondence between the aspirations manifest in the ideal consultation models and everyday practice was construed as a technical deficiency of doctors' communication skills. Texts were written with the purpose of addressing this disparity⁴⁶. They identified skills and strategies which doctors might develop to rectify perceived inadequacies in their communication skills. This emerging emphasis on the centrality of communication in the care process in general medical practice confounded the decline in the importance of communication seen in other more technological fields of modern medicine⁴⁷. The need for doctors to develop new and better communication skills was buttressed by the prevailing political and social trends which throughout the 1970's and 1980's saw the advocacy of patient interests and the emergence of ideas about consumerism¹¹.

As Middleton observed⁴⁸:

"Understanding the nature of consultations is vital to the development of the discipline of general practice. The problems which patients bring to general practitioners are undifferentiated and our job is to make sense of them. The increasing importance ascribed to the ethical and social value of autonomy leads to the view that more weight needs to be given in analysis of consultations to the concepts, perceptions, views and rights of patients."

This statement about the content of consultations brings into sharp relief the communicative practices used in the consultation. By the time Middleton was writing in 1989, the centrality of communication in the general practice consultation was widely accepted. Calls for greater medical recognition of the legitimacy of lay knowledge and experience had been assimilated by professionals and repackaged as a need to review the prevailing mode of operation by doctors within the consultation. The doctor's behaviour was seen as the reason why the

patient's perspective was routinely undervalued in the consultation and in consequence a shift from a "co-operation-guidance" model of doctor-patient relations to a mutual participation model in which responsibility and power are shared was advocated. Wensing's systematic review of the literature on patient priorities for general practice care confirmed that patients regard exploration of their needs, involvement in decisions, and informativeness as important aspects of general practice consultations⁴⁹. The espousal of patient-centredness can be seen as the professional response to this call to be more sensitive to patients' needs and to involve patients more in their care.

Patient-centredness

The generation and evolution of models for the ideal consultation have led to a consensus about what constitutes appropriate style in the practice of consulting. The models are essentially prescriptive and skills based, and have been widely used in undergraduate and postgraduate training. In parallel the concept of patient-centredness has gained prominence. It has been suggested this does not reflect a new ideology but a re-emergence of a philosophy for practice centred around concerns for the primacy of the person and the significance of the subjective which has its roots in historical writings about holism. Given the trends evident beforehand, in particular the re-emergence of the patient as person, the materialisation of the concept of patient-centredness was perhaps inevitable. Its characterisation was indicative of the need to objectify the subjective, and to make explicit those elements of patient care that hitherto had been implicit.

Definitions of patient-centredness

Definitions of patient-centredness have not often been clear and unambiguous. Indeed in some research they have not even been explicit. This lack of clarity has served both to obfuscate the concept of patient-centredness itself and to cast doubt on its effects.

a) Patient-centredness as clinical method

Much recent writing in this field has objectified patient-centredness as a “clinical method”. The purpose of the method is to enable the physician to gain an understanding of the patient as well as his disease⁵⁰. This approach has found favour in general practice precisely because pathological diagnosis or a disease-centred clinical method, venerated in undergraduate medical curricula, was failing to help doctors understand the illnesses patients were presenting to them. Medical education tends to lead students to believe disease is resident in the individual body and that the symptoms and signs of disease are direct reflections of disorder of the structure or functioning of the body. The natural course of disease is outwith the control of the individual patient. The narrative of illness experience and the person who is suffering is relevant only in that it contains the clues to pathophysiological disorder. The clinical narrative conceives the patient as person only insofar as patients are seen as morally responsible for their diseases, for example the smoker with chronic obstructive pulmonary disease, or seen as willing compliers with prescribed treatments. This view of medical practice is of course something of a generalisation. For experienced doctors treating the patient who is ill, rather than their disease, becomes the priority. However the presence of illness in the biological domain is presumed and although doctors do not routinely ignore

behavioural and experiential matters, they are considered as separate from the real object of medicine, biological disease.

The development of the patient-centred clinical method is closely linked to these perceived limitations in the conventional way of doing medicine. In the patient-centred clinical method, the aspects of the patient, as opposed to their disease, the physician needs to understand include their beliefs, fears, ideas, preferences, and expectations. These aspects are generally referred to as the “patient’s agenda”, and eliciting this agenda is incorporated as a key task in most consultation models. Thus the resonance between ideal consultation models and the rhetoric of patient-centredness is clear. Authors have sought to describe how this relationship can be operationalised. Henbest and Stewart⁵¹ defined patient-centredness as a response by the doctor to a patient’s “offer” in a way that allows the patient to express all of his or her reasons for coming to the doctor, including symptoms, thoughts, feelings and expectations. Later Stewart⁵² outlined a more goal orientated definition which included six components: exploring both the disease and the illness experience; understanding the whole person; finding common ground regarding management; incorporating health promotion and prevention; enhancing the doctor-patient relationship and being realistic. Latterly this definition has become the basis of an international consensus about what constitutes patient-centredness.

Winefield and her team⁵³ describe what patient-centredness implies for clinical communication style. Among the features of a patient-centred clinical communication style they identify is greater involvement of the patient in decision making and planning of their treatment. Indeed involving patients in decisions has long been considered a cardinal feature of patient-centred communication and Elwyn used qualitative methods to propose a set of communicative competencies that would enable general practitioners to undertake shared decision making in

consultations⁵⁴. In a further study with Wensing he explored the relationship between patient-centred communication and shared decision making and found that the two concepts were only weakly associated, suggesting that the concepts could be differentiated⁵⁵. The explanation for this finding may lie in the notion that patients do not all or always want to be involved in decision making to the level some proponents of the benefits of patient-centred consulting suggest⁵⁶. Furthermore, as Stewart states, patient-centredness does not require that all decisions involve patient participation but that doctors should “take into account the patient’s desire for information and respond appropriately”⁵²

b) Patient-centredness as a dimension of the doctor-patient relationship

An alternative interpretation of the term patient-centredness is to see it as a description of characteristics of the doctor-patient relationship. Mead and Bower⁵⁷ reviewed the conceptual and empirical literature about patient-centredness and derived a theoretical framework for patient-centredness that encompassed those aspects of the doctor-patient relationship considered integral to the concept. The dimensions they identified were biopsychosocial perspective; patient-as-person; sharing power and responsibility; therapeutic alliance and doctor-as-person.ⁱⁱⁱ They concluded that 3 of these 5 dimensions were most readily amenable to quantification. The dimensions of doctor-as-person and patient-as-person were considered least amenable.

ⁱⁱⁱ Biopsychosocial perspective refers to the expansion of the explanatory model for illness beyond biomedical considerations to include psychological and social factors. The patient-as person aspect encompasses consideration of the patient’s experience of illness and its meaning in the context of his or her biography. Sharing of power and responsibility promotes the idea of an egalitarian doctor-patient relationship in which doctors and patients share power and responsibility in respect of the patient’s health. The therapeutic alliance relates to the personal relationship between doctor and patient and its effect on outcome independent of biomedical interventions. The doctor-as-person dimension concerns the influence of the personal qualities of the doctor.

Measures of patient-centredness and outcomes

The association between concepts of patient-centredness and models of ideal consulting practice is clear. The definitions of patient-centredness applied in research are inextricably linked to attempts to develop measures of patient-centredness. Measures of patient-centredness are important in the task of generating empirical evidence of the benefits to the patient of a patient-centred approach. Since operationalisation of patient-centredness has concentrated on doctors' communication practices, the measures developed have mostly been based on quantification of communicative behaviours. A smaller number of measures have been developed based on self reports of doctors characteristics reflecting the idea of patient-centredness as an attitudinal characteristic of doctors⁵⁷.

Measures of the patient-centredness of physicians' behaviour in consultations are based on external observation of consultations. They rely on rating how well or how much of a specific behaviour, deemed necessary for the application of patient-centredness, was performed in the consultation^{53,58,59}, or on coding specific units of speech or verbal behaviour in the consultation^{53,59,60;61}, or on a combination of both of these^{51;62}. Rating of behaviours in consultations tends to focus on instrumental or task orientated behaviours such as eliciting the patient's views, following the patient's ideas, and involving the patient in decision making, rather than on the affective tenor of the interaction. The score is a subjective assessment of the behaviour observed by the rater. Scales coding verbal behaviour usually allocate each utterance in the consultation to mutually exclusive categories in schemes such as Bales Interaction Process Analysis⁶³, Stiles Verbal Response Modes⁶⁴ and Roter's Interaction Analysis Scheme⁶⁵. Categories deemed as patient-centred are then used in analysis.

The measures of patient-centredness described above are based on experts' ratings of observed doctor behaviours in the consultation. Little et al have taken the seemingly logical step of saying that adjudication on the patient-centredness of consultations should be made by patients⁶⁶. Therefore they set out to document measures of patients' perceptions of patient-centredness in consultations. They suggest that there are five distinct components of patients' perceptions that can be measured reliably: communication and partnership; personal relationship; health promotion; positive approach to diagnosis and prognosis; and interest in the effect on the patient's life.

Self-reports of their characteristics by doctors have also been used to indicate their patient-centredness. Grol et al developed a questionnaire assessing doctors' "patient orientated" attitudes and categorised doctors on the basis of their responses into doctor/disease-centred or patient-centred⁶⁷. Cockburn et al assessed doctors' attitudes to medical care⁶⁸. This scale was not specifically designed to assess patient-centredness but components of it relate to attributes generally accepted as integral to definitions of patient-centredness, and for this reason it has been used to categorise doctors. I shall return to these endeavours later in this chapter.

Howie and his colleagues have made a case for measuring the quality of interpersonal care from the standpoint of the outcome of consultations for patients rather than just from observation of the process of consultations. Their patient enablement instrument focuses on patients' understanding of their illness and their ability to cope with it, which are regarded as important outcomes of patient-centredness. Over a series of consultations they therefore suggest that doctors who are more patient-centred will achieve higher enablement scores⁴⁰.

Despite these efforts to quantify and rate patient-centredness, none of the methods has gained universal acceptance. This not only highlights the ongoing contention over definitions of patient-centredness but also presents a problem in terms of evaluating the benefits or otherwise of patient-centredness. The following section addresses the literature reporting outcomes of patient-centredness.

Outcomes of patient-centredness

The rationale for adopting a patient-centred clinical method lies in the belief that it will lead to better health related outcomes for the patient. This expectation is founded on the prospect offered by a patient-centred method of more clearly identifying individual patient need and responding to it appropriately. Despite ethical and moral arguments for its virtue empirical evidence for the beneficial effects of patient-centredness is far from compelling.

Demonstrating a clear relationship between a patient-centred process and positive patient outcome requires not only a measure of patient-centredness, but also agreement about what constitutes positive patient outcome. Studies have rarely used the same measures of patient-centredness, nor reported equivalent outcomes. For example some studies have isolated specific aspects of patient-centredness or patient-centred clinical method and reported on their associations. Whereas other studies have used global measures of patient-centredness and reported generic outcomes. Lassen⁶⁹ examined the relationship between the characteristics of the communication in a consultation and patient compliance. He found the aspects of the communication which predicted patient compliance were: talk about the patient's expectations for the consultation; talk about the patient's ideas about the health problem; information about the content of the advice; explanation about the effect and relevance of the advice; talk about the patient's assessment of the

quality of the advice; and talk about the obstacles to complying with advice. Despite the similarity between these aspects and the axioms of a patient-centred method, Lassen does not use this term. However his results do offer some support for benefits of adopting such an approach.

Grol⁶⁷ also provided tentative support for a patient-centred approach by demonstrating correlation between doctors having a less patient-centred attitude and more prescribing of symptomatic medication, inadequate psychosocial performance in the consultation, lack of openness to patient's ideas and lack of information giving. Similarly Howie, Hopton et al⁷⁰ using components of Cockburn's scale⁶⁸, identified attitudes which correlated with processes of care previously considered as indicators of good quality care. They grouped doctors according to their responses and designated one group as patient-centred on the basis of their responses on three of the seven sub-scales (responsibility for decisions, psychological orientation and appropriateness of consultations). These patient-centred doctors provided higher quality care particularly in terms of dealing with psychosocial need. However dimensions measured by other sub-scales that could be considered as equally axiomatic of patient-centredness (mutuality and communication) did not correlate with any indicators of quality.

Henbest and Stewart built upon their earlier work with Brown⁶² to work to devise a method for measurement of patient-centredness⁵¹. They used the resultant combined measure to quantify the extent to which a consultation was patient-centred by analysis of the verbal exchanges between patient and doctor in the consultation. They analysed doctors' responses to patients in terms of their ability to allow patients to express all their reasons for coming, including: symptoms, thoughts, feelings and expectations. They then looked at the associations between their measure of the degree of patient-centredness in a consultation and six

specific outcomes. Their chosen outcomes were ascertainment of patient's reason for attendance, doctor-patient agreement about the condition, patient feeling understood, patient satisfaction, resolution of symptoms, and resolution of concern about seriousness of main symptom. They found statistically significant associations only between the degree of patient-centredness of a consultation and resolution of the patient's concerns, and ascertainment of the patient's reason for attendance.

Proponents of patient-centred clinical method claim it achieves positive outcomes for patients in many areas. Yet the evidence for this remains contradictory. Patient-centredness has been shown to enhance the effectiveness of communication⁷¹, increase patient satisfaction with consultations⁷², and increase patient wellbeing⁷³. Paradoxically Mead et al found that general practitioners' patient-centred behaviours did not predict either patient satisfaction or patient enablement. The reasons for this may lie in the difficulties they experienced in operationalising through analysis of video-taped consultations more than three of the five dimensions of patient-centredness they identified in the literature⁷⁴. Little et al demonstrated that certain components of patients' perceptions of patient-centredness predict different outcomes⁶⁶. They found patient satisfaction was related to patient perceptions of communication and partnership, and enablement to patient perceptions of the doctor's interest in the effect of their problem on their life. Faith in the principles of patient-centredness and their potential to bring benefits to patients means that the existence of only modest evidence in its favour is regarded as an artefact of measurement rather than a flaw of the concept. The quality of the interpersonal aspects of care remains integral to definitions of effective care⁷⁵. Yet the processes and outcomes are context specific for each

individual person which may make them less amenable to measurement. The consultation quality index (CQI)^{iv} is an attempt to aggregate assessments of the process and outcome of a number of consultations to indicate the quality of interpersonal care offered by an individual doctor⁷⁶. Bearing in mind the relationship between the individual components of this index and patient-centred values, its proponents consider the CQI to be a proxy measure of the patient-centredness of the doctor⁷⁷.

The concept of patient-centredness arose out of concern for the subjectivity of the patient, and for how best to take account of it. The models of the consultation upon which this vein of research is based have taken as their primary focus the things doctors do with patients. It found favour in general practice precisely because pathological diagnoses were failing to help doctors understand the illnesses patients were presenting to them. Gaining an understanding of the patient as opposed to their disease was being recognised increasingly as a way for physicians to reach an understanding of the patient's illness. In comprehending the patient's agenda, the doctor also gains insight into the context of the patient's illness. This understanding is considered to be particularly useful for it allows the doctor to reconcile the patient's agenda with his own and facilitates the patient's problems to be managed in the most apt way for them as an individual. It is possible to argue therefore that patient-centredness in fact represents another attempt to objectify the patient but this time according to a different set of rules. Patient-centred clinical method is still prescriptive in terms of style and doctor behaviour. Thus when doctors fail to meet the criteria for patient-centredness it is seen as a technical deficiency of the doctor's communication skills. Thus it

^{iv} This amalgamates information on doctors' mean consultation length, how well their patients know them (a proxy for personal continuity of care) and the extent to which they "enable" their patients.

problematizes the doctor, and neither the patient nor the doctor are able to express their subjectivity appropriately. In essence while patient-centredness intends to convey an holistic concept, in practice it probably fails to express the “indivisible whole of a healing relationship”⁵². This brings into focus the fact that the relationship between doctor and patient in the general practice setting is not merely a technical device for the delivery of medical care but also a moral enterprise founded on personal conscience and trust. This brings me to the final theme I identified in the literature about the general practice consultation.

The consultation as a moral encounter

Patient as person in the general practice consultation

As I have stated previously, the re-emergence of the patient as an experiencing individual was crucial to the development of the nascent discipline of general practice, providing a way for it to differentiate itself from specialised hospital medicine. Whilst the latter continued to privilege the biomedical aspects of disease in the treatment of illness, general practice and general practitioners recognised the interconnections between the physical, psychological and social aspects of their patients' ill-health. One corollary of accepting this formulation of ill-health is that every aspect of the patient is then befitting of medical attention. Hence the patient's personality and social relationships were deemed legitimate foci of medical attention. In terms of the general practice literature the apotheosis of this approach is the work of Balint¹⁸. He was largely responsible for the abstraction of the interaction between patient and doctor as an intrinsically therapeutic entity. He outlined how patients experienced illness in the absence of pathological disease and proposed that the basis of their illness lay in the problems (social,

psychological, emotional) in their lives. He highlighted how the patient's subjectivity has implications for understanding their behaviour and their reactions to the doctor. And in so doing he re-aligned the role of the doctor in the interaction. The doctor was no longer to rely exclusively on objective biomedical technologies to cure disease but was required to deploy some part of himself (the drug doctor) to alleviate suffering.

Balint's work not only cemented the centrality of the doctor-patient relationship in general practice but also established a new rationale for the doctor-patient relationship. The extent to which his ideas have been accepted within the mainstream of general practice is debatable. However it is clear that they were the launching pad for much of the ensuing work on the consultation process. Browne and Freeling⁷⁸ were among the first to offer an academic analysis of the interaction between doctor and patient. Building on Balint's work they affirmed "whole problem care" as the task of medicine. They specifically endorsed the general practitioner's role as "to understand the whole of his patient's communication so that he could assess the whole person and be able to consider the effect of any intervention in an illness upon the whole life of his patient". Thus the emphasis was on who the patient was, not just what his disease was or how his disease was treated. In this way the doctor was expected to extend his "gaze" beyond the clinical condition of the body and to intrude into the patient's private subjective space. This "holistic" or whole person approach to care was embraced by the fledgling Royal College of General Practitioners in "The Future General Practitioner", a guide to the teaching of general practice²⁰.

One key concept of a holistic approach to the consultation is that the interaction then becomes understood not in terms of behaviour or rational cognition but in terms of the feelings of those involved. For the patient to feel better does not

demand objective improvement in the patient's physical health. Rather it requires that the patient makes better sense of their illness and adjusts to it more appropriately. As Toon says⁷⁹

"The consultation is the patient's forum for coming to understand her illness; not merely a rational understanding but an understanding which involves the emotions and which contributes to the growth of the individual."

Consultation as therapeutic encounter

This interpretation of the consultation is essentially a moral, humanistic one, and is congruent with the interpretative model of medical practice outlined by Toon⁷⁹. There is no sanctuary for the doctor in the technologies of the science of medicine. Instead the doctor must be "bodily empathic"⁸⁰ with the patient. This has been defined as the ability to identify imaginatively with the patient's subjective experience of illness to provide genuine recognition and validation of that experience. Combining this with objective understanding of the working of the body, the doctor gains a depth of understanding that allows him to work with the patient to make sense of the patient's experience of illness. This interpretation hints at the healing potential of the relationship between doctor and patient and its perspective is echoed by Pellegrino⁸¹:

"The generalist cannot take refuge in the limitations of his specialty. For him the healing relationship must be entered into in the fullest sense... He must help, care for, comfort and ease when the specialist has nothing to offer....Even if the patient's illness has been negotiated out of medicine by other physicians, someone must remain who can help. The generalist on this view is the physician par excellence since he has the most intimate relationship with the healing and helping functions of medicine..."

The roles of the general practitioner in the moral encounter

Where does this interpretation of the consultation leave the general practitioner? Iona Heath in "The Mystery of General Practice" defines the key roles of the general practitioner in the consultation to be "to serve as an interpreter and guardian at the interface between illness and disease, and to serve as witness to the illness experience."⁸²

Peter Toon in his "Towards a Philosophy of General Practice: a Study of the Virtuous Practitioner"⁸³ similarly views the doctor's role as one of friend, pastor, guide, and witness. The responsibilities implicit in such a role involve helping the patient to make sense of their illness and to integrate it into their life narrative. Hence the doctor is engaged with the patient in their search for meaning in life.

McWhinney⁸⁴ emphasises that beyond witnessing, responding to his patient's suffering is also a key role of the general practitioner, and that how events unfold subsequently is profoundly influenced by this initial response. He points out that responding to suffering is a "moral obligation" and not conditional on evidence of its effectiveness. Thus the role of the general practitioner is above all a moral one. Deploying this role in a consultation relies upon a bond of mutual trust and respect between doctor and patient. As James McCormick commented⁸⁵:

"Illness has an emotional component that leaking cisterns do not share. The experience of illness with its threat to our own survival reduces us all to childlike dependence. We need somebody to take away both the pain of disease and the pain of uncertainty. That somebody must be invested with trust: trust to do what is best for us irrespective of other competing claims on time and energy."

Continuity of care and personal doctoring

Furthermore these activities are unlikely to be accomplished in a single encounter. Therapeutic relationships occur in contexts where there is mutual trust and commitment between doctor and patient. Trust in a doctor develops out of ongoing continuity of responsibility and doctors develop a sense of responsibility for individual patients with repeated contact⁸⁶. Continuity of care for individual patients has been central to definitions of the role of the general practitioner such as those outlined earlier in this chapter. Traditionally this has meant that the patient attends the same doctor over a period of time encompassing various episodes of ill-health. The accumulated knowledge the doctor gains of the patient and their personality, their illnesses and their social context, over time are presumed to influence the care the patient receives. Support for the benefit of personal continuity is found in patient evaluations of care which show increased satisfaction^{87;88}, and better enablement when the patient knows the doctor well⁴¹. Improvements in patient compliance with prescribed medication⁸⁹ and accuracy of diagnosis have also been associated with doctors knowing their patients well⁹⁰. In general practice these sorts of ongoing relationships have been characterised as providing personal care and the doctors in the relationships have been designated as “personal” doctors. Hence there has been conflation of the personal dimensions of a relationship between doctor and patient with the concept of continuity. Although there is no reason to assume that repeated contact guarantees a good, close or healing relationship between doctor and patient, it does accentuate the moral dimensions of the encounter.

The doctor's subjectivity

This view of the nature of consultations and the role of the general practitioner throws into sharp relief the subjectivity of the doctor. In a biomedical model where the application of diagnostic and therapeutic techniques is seen as a purely objective endeavour, doctors are in effect interchangeable. Their personal qualities are subservient to their technical expertise. Whereas viewing the consultation as an intrinsically moral encounter acknowledges that, in the same way that patients bring more than their bodies and diseases into the consultation, so too doctors bring more than their technical knowledge and skills. The doctor's lifeworld and subjective experiences are part of his medical practice. This perspective, like all views of the nature of general medical practice, is underpinned by a set of attitudes, values, and beliefs as much as by a set of technical skills.

If we are to understand doctors' subjective experiences of their work, then we need to reflect upon the source of their expectations of these experiences. The influence of medical training cannot be underestimated. With regard to medical students' training, studies^{91,92} indicate that undergraduate medical education teaches students to view emotions as unhelpful and to accept the pre-eminence of the biomedical model based on scientific rationality. Furthermore Good⁹³ suggests that learning medicine is not just about acquiring new knowledge and learning new ways of solving problems but is about gaining entry into a new lifeworld. Entry into the world of medicine is accomplished not merely by learning the language and knowledge base of medicine but also through learning the practices through which practitioners engage with and formulate reality in a specifically medical (biomedical) way.

Recent changes in undergraduate medical curricula in the UK, some following the General Medical Council's publication of *Tomorrow's Doctors*⁹⁴ may have gone a

little way to rectifying this imbalance by including courses in social science, medical humanities, communication and ethics which complement the standard instruction in clinical method. Nevertheless these courses still constitute a small part of medical curricula and junior doctors working in hospitals tend to view psycho-social issues as being at the margins of medical practice. Therefore much of the training in the general practice registrar year is focussed on redressing deficiencies not in biomedical knowledge but in the “personality” of the doctor. To quote Denis Pereira Gray, vocational training entails a movement away from “the characteristics of rigidity, authoritarianism and cynicism towards a doctor committed to patient-centred medicine, that is a form of medicine that seeks to interpret the wishes of the patient and to respect the patient’s autonomy”⁹⁵. Indeed the examination of the Royal College of General Practitioners aims to test competence in whole person medicine, with its focus on the technical skills, in particular communication skills, and the attitudinal commitment to patient-centredness deemed necessary for the practice of whole person medicine.

Doctor-as-person

From the foregoing it is apparent that general practitioners are susceptible to a range of, sometimes conflicting, socialising influences that will underpin their experiences of their work. Furthermore the same socialising influences will inform the development of a set of professional attitudes, values and beliefs which will influence their professional practice. Toon⁸³ has made a comprehensive exploration of the qualities needed to practice “good medicine” which he defines in terms of the attributes of the “Virtuous Practitioner”. He views medicine as a purposive practice and “good medicine” as a moral enterprise that makes particular and specific demands of its practitioners. To meet these demands practitioners require particular qualities – those of the “Virtuous Practitioner”-which are developed in

turn by the practice of medicine. Toon identifies these qualities as the virtues of moral courage, prudence, temperance, faith, hope, charity and physical virtue and locates these qualities within a meta-ethical framework. In Toon's theory moral courage is involved in good medical practice in, for example, facing patients' pain and mortality, coping with the "heartsink patient" and dealing with a colleague who is not fit to practice. Prudence is involved in the ability to link technical and moral judgements to achieve right ends - a quality that resounds with the notion of "sound clinical judgement". Temperance is required in respect of achieving a balance between work and home, and in respect of avoiding over-treatment of patients. Faith involves fidelity to patients, and hope a belief that what one does is of some value that is sustained without dishonesty when there is very little that can be done. Charity involves a genuine concern for the patient and a delight in their positive features and includes altruism and a commitment to person-centredness. Finally physical virtue requires of doctors a responsible approach to their own physical well-being. This view of the desirable qualities of a doctor may not be universally held not least because it is possible to value different sorts of behaviours whilst remaining within an essentially moral framework. However Toon's work clearly highlights the important contribution the practitioner as person makes to the nature of the care he delivers.

Recognition of the contribution of the individual attributes of doctors to the character of individual consultations and to the nature of the care delivered within them has led to attempts to either categorise doctors or to "measure" their attributes. The rationale for categorising doctors relies upon using such categories to understand or predict general practitioner behaviour.



a) Categorising of doctors: practice orientation and attitudes

Mechanic made one of the earliest attempts at such categorisation of general practitioners⁹⁶. He combined evidence of the behaviour of general practitioners, specifically relating to their use of diagnostic tests, with information obtained from questionnaires measuring their acceptance of a social role as part of their work. He scored their acceptance of a social role by assessing their responses to two questions: one asking if the general practitioner considered it proper for patients to consult them about family financial troubles, disobedience of children, marital difficulties, how to handle behaviour such as drunkenness in a relative, children's poor performance at school, birth control advice, alcohol problems, general feelings of unhappiness, anxieties about child care, and obesity; and the second examining their reaction to a trend outlined in the following paragraph.

"Some medical commentators have recently argued that there is a growing tendency for people to bring less serious disorders to doctors and more readily to seek help for problems in their family lives. In general do you feel that this is a good or bad trend, given present conditions of medical practice? Do you find this- very good, good, rather disturbing or very disturbing?."

He consequently derived four types of general practitioner whom he labelled withdrawers, technicians, counsellors and moderns.

A withdrawer was characterised by low use of diagnostic tests and a low social orientation score, a technician by high diagnostic use but low social orientation, a counsellor by low use of diagnostic tests and high social orientation and a modern by high diagnostic use and social orientation. Mechanic found many more withdrawers and counsellors than technicians and moderns but experienced difficulty in accounting plausibly for differences between doctors in terms of their practice orientations.

Mechanic's polarisation of doctors into those with a high social orientation and those with a low social orientation has subsequently been criticised as simplistic. Authors have sought to develop more sensitive and subtle categorisations of practice to reflect the changing role of general practitioners. Foremost among these efforts was Calnan's survey of over 2000 unrestricted principals in England and Wales⁹⁷. On the basis of the findings of this survey he sought to validate a typology of practitioners suggested by Huntington⁹⁸.

Huntington had developed her own six fold typology through reflection on general practitioners relationships with social workers. She suggested that all general practitioners fell into one or other of the six following categories: real doctor; father figure; internal physician; family doctor; psychophysician; and psychotherapist. Calnan took three different but related dimensions of Huntington's classification to distinguish different orientations towards the role of general practitioners: orientation towards medicine; relationship with patient and relationship with other professionals and examined how valid these three dimensions were as a way of conceptualising general practitioners' views about their role. Using these three dimensions Calnan constructed a scale to measure general practitioners' orientations towards their work. The results from his survey revealed inconsistencies with Huntington's typology, that is general practitioners' own ideas about their work did not fit with the typology. Calnan suggested this may be due to the typology reflecting institutional rhetoric about the nature of general practice rather than the day to day reality experienced by practitioners. Calnan concluded that Mechanic's classification might be more valid than critics had suggested and that in reality general practitioners' perceptions about their work role had developed little in the intervening decade, and that the medical orientation/social orientation dichotomy still existed. A decade or so later Dowrick et al's questionnaire study of general practitioners' views on the acceptable boundaries of their clinical practice⁹⁹ suggested that the situation may in fact be even simpler

than that, and highlighted again the mismatch between the rhetoric of practice and everyday reality. For while the rhetoric of general practice continued to encourage adoption of a biopsychosocial approach to practice, and inclusion of a range of practice unanticipated a quarter of a century ago, the “reality” of general practitioners’ views of their practice was very different. Respondents consistently rated appropriate the presentation and management of physical problems, were ambivalent about psychological topics and consistently deemed social problems inappropriate for presentation to and management by general practitioners.

Interest in developing characterisations of doctors that explain and predict behaviour led Bucks et al to produce a more complex analysis of general practitioners attitudes. They were particularly concerned with characteristics that might predict prescribing and referral behaviour¹⁰⁰. They modified a questionnaire devised and validated by Grol¹⁰¹ addressing general practitioners’ views about how responsible they were for a range of medical and psychosocial tasks, how competent they felt in carrying out those tasks, and what sorts of feelings they had when dealing with these tasks. The questionnaire also included attitude statements about external control of general practice and taking risks with patients’ health. Responses on the questions about the roles and responsibilities of general practitioners were considered to reflect a normative view of the general practitioner and were therefore excluded from the analysis. Five types of doctor were produced based on responses to questions about external control of general practice for example by government, risk taking in respect of diagnosis and management of patients’ illnesses, and information giving to patients. The types of doctor that emerged were characterised by clustered approaches to these issues and were designated egalitarian, optimistic and confident; traditional and speculative; traditional, older-style and careful; doctor centred preferring caution and prevention; and balanced and patient-centred. In effect the study identified

trends in general practitioners' attitudes but the complexity of the resultant typology militates against its utility.

b) Association between doctors' orientation and personal attributes

Mechanic⁹⁶ concluded that his modern orientation was the most closely aligned with the Royal College of General Practitioners' view of ideal general practice, and that moderns were over-represented amongst doctors working in smaller communities, in group practice, with an appointment system, undertaking course work and in contact with other doctors. However it is unclear whether moderns develop this practice orientation through exposure to these characteristics of their work or whether they choose to practice in these circumstances because they have a modern orientation.

Calnan⁹⁷ having retreated to a position in which general practitioners were once again seen as belonging to one orientation or another, also examined whether specific orientations were associated with personal characteristics, work settings and forms of patient care. He found general practitioners with a social orientation were more likely to be female, under 35 years of age, recent recruits to general practice and to have qualified in the UK. They were also more likely to be trainers, to have received vocational training and to be members of the Royal College of General Practitioners. These characteristics are entirely unsurprising and certainly not independent of each other. Working in a rural location increased a practitioner's likelihood of having a social orientation, as did increasing partnership size. Longer consultation length was associated with social orientation, as was provision of health education and health promotional activities. Many of the relationships Calnan described between practitioner characteristics and orientation were only marked at the extremes of his typifications. This suggests that a typology of the sort he and Mechanic suggest is too blunt an instrument to differentiate between the majority of general practitioners. Whilst explicitly

claiming to identify similarities among groups of general practitioners in truth most classifications identify differences and ascribe at times spurious significance to these. In conclusion it has proved difficult to categorise practitioners satisfactorily on the basis of the content of their work and their attitudes to it. A related approach to understanding general practitioners behaviour is the development of scales to measure their beliefs and attitudes.

c) Scales to measure general practitioners' attributes

Social psychological research has suggested that attitudes held by individuals predict their behaviour in related areas and therefore it is postulated that by measuring practitioners' attitudes to particular dimensions of their work their likely behaviour can be predicted. Cockburn et al developed a questionnaire to measure the attitudes of general practitioners towards their role in medical care⁶⁸. Seven factors emerged to be used as independent sub-scales to measure the opinions of doctors. The first sub-scale was psychological orientation which describes the extent to which practitioners believe recognition and treatment of psychological or emotional problems to be an important part of their role. Interestingly none of age, sex or postgraduate qualifications influenced responses on this sub-scale. The second sub-scale measured practitioners' attitudes to the role of government in the delivery of medical care and although overall the sample was opposed to government involvement, differences were demonstrated between the views of younger and older doctors and female and male doctors: older and male doctors being more opposed to government intervention. Attitudes towards implementing preventive strategies in general practice constituted a third scale. Practitioners generally accepted this was an important component of general practice but were less confident they were successful at it. Three further sub-scales described the practitioners' perceptions of mutuality in the relationship between doctor and patient: firstly the extent to which doctors believe patients

should be equal and active participants in the consultation; secondly, the importance of communication between doctor and patient in the consultation; and finally the extent to which general practitioners believe patients want to be involved in decision making in the consultation. Complex relationships were demonstrated between responses on each of these scales and practitioners' age, sex and postgraduate qualifications. The seventh scale explores whether practitioners are concerned by consultations they consider trivial or inappropriate. The authors suggest scores on this scale may indicate doctors' satisfaction with their role. Age, sex and postgraduate qualification seemed not to influence responses on this scale. Cockburn et al were not attempting to aggregate responses on multiple sub-scales to produce types of doctor as each of their sub-scales were independent. It was considered that responses on specific scales would predict physician behaviour. However Howie, Hopton et al⁷⁰ having grouped doctors according to their responses on Cockburn's scale found that doctors designated as patient-centred were more stressed during consultations. They attributed this stress to person role conflict arising from patient-centred doctors working in a way which did not accord with their personal values or interests.

d) Characteristics of patient-centred doctors

Of late the pre-eminence of patient-centredness in the discourse about general medical practice has led to doctors' patient-centredness assuming cardinal importance among their individual attributes. Characteristics that predict patient-centredness have been investigated. Female doctors are more likely to be patient-centred than male doctors¹⁰² and trainers more than non-trainers. In other settings similar associations have been demonstrated¹⁰³. Indeed a doctor's patient-centredness has come to be regarded as a proxy for the quality of interpersonal care he provides.

The basis for much of this research about the qualities and orientations of individual doctors lies in concern for the subjectivity of doctors. However, unlike with patients where the motive for interest in their subjectivity is to take account of it in the interaction, the focus with doctors is on identifying and modifying perceived prejudices and biases that might influence their practice. In other words there is an unwritten presumption that the doctor's subjectivity is remediable.

In many respects this process constitutes an attempt to objectify the doctor according to parameters delimited by institutional rhetoric about general medical practice. Real concern for the doctor's subjectivity accepts that it is an inherent part of the doctor-patient relationship and that "the doctor and patient are influencing each other all the time and cannot be considered separately" ¹⁸. Furthermore consideration of the doctors' subjectivity within the doctor-patient interaction cannot omit exploration of their motives, that is their reasons conscious or otherwise for certain courses of action, and their understanding of the significance and value of those actions.

Doctors' experiences of their work.

In Neighbour's "The Inner Consultation"¹⁰⁴ doctors' responses to consultations are characterised as an ongoing internal dialogue between the organising and responding aspects of the doctor's brain. The intuitive responsive aspects of the doctor are rationalised by the organising characteristics so that only responses deemed helpful are admitted into the consultation. This is probably overly optimistic. Nevertheless Neighbour recognises that the doctor has a subjectivity albeit rather disengaged and fragmented, which might produce disobliging responses in consultations and be the source of difficult or dysfunctional

interactions. Thus doctors themselves are problematised. Studies in which general practitioners have self-reported their experiences with patients have tended to focus on interactions with patients with conditions that have been problematic for the doctor in terms of the interaction within the consultation, for example patients with medically unexplained symptoms^{105,106}, drug abusing patients¹⁰⁷, patients with chronic low back pain¹⁰⁸, depressed patients¹⁰⁹, and "heartsink patients"¹¹⁰⁻¹¹³. The source of doctors' negative reactions and responses in interactions with such patients has proved a fertile field of investigation. These patients are seen to share the characteristic of presenting manifestations of psychological, emotional and social distress in consultations, and the doctors' responses to them are characterised by feelings of powerlessness, frustration and pessimism.

Doctors' job satisfaction

The interaction with patients has featured strongly in studies in which the causes of job dissatisfaction in general medical practice have been explored. In an early study¹¹⁴ dissatisfaction was focussed on unnecessary consultation about trivial complaints whereas later studies have emphasised doctors' disillusion with the psychosocial aspects of general practitioners' work¹¹⁵. Although in a recent postal survey of general practitioners¹¹⁶ many of the sources of dissatisfaction and stress identified were related to factors outside the consultation^v, the highest ranking sources of job stress remained dealing with problem patients and worrying about patient complaints. Winefield et al also found in their study of the sources of

^v For example dividing time between work and family, disturbance of home family life by GP work, and adverse publicity in the media.

occupational stress^{vi} for Australian general practitioners that two thirds of the stressors described by doctors arose from their interaction with the patient¹¹⁷. These findings strongly suggest that the interactions between doctors and patients are the basis of much of doctors' experiences of their work.

Early work by Mechanic on general practitioners' job satisfaction led him to suggest that "frustrated doctors tend to be poorer doctors and are willing to take undesirable short cuts"¹¹⁸. Indeed the rationale underpinning much of the research about job satisfaction is the presumption that there is a relationship between a doctor's experience of work and the quality of patient care. Grol and his colleagues¹¹⁹ explored doctors' work experiences by examining the nature and frequency of given affective responses to aspects of their work: helping patients with diagnosable physical complaints; helping patients with psychosomatic or psychosocial complaints; and being involved in extra activities in addition to consulting and home visiting. They then sought correlations between the degree of positive and negative feelings about their work and the quality of care they delivered. Examination of process variables in their consultations was used to assess the quality of care. Positive feelings correlated with more openness to patients, more attention to psychosocial aspects of complaints and a higher referral rate to specialists. Negative feelings correlated with high prescription rate and giving little explanation to patients. The authors suggested their findings provided some evidence to support the contention that the way work is experienced by general practitioners correlates with the quality of care for patients but admitted that "what constitutes cause and effect requires further study".

^{vi} Stress and the general practitioner is a heavily researched area. Much of the research focuses on wider structural and organisational issues for general practice. However I have restricted the scope of this review to those factors within the doctor-patient interaction that impact upon the doctor's satisfaction and stress.

Furthermore the feelings described in Grol's study were not those evoked by the consultations being assessed, but reflected a global assessment of their orientation to their work. The feelings were in effect an objectification of the doctor rather than an expression of their subjectivity. In other words they were separated in time and space from the events to which they were being related.

Doctors' satisfaction with consultations

Attempts to explore doctors' feelings about specific consultations have been limited. Doctor satisfaction with consultations has been reported as a secondary outcome in some studies about the general practice consultation. Generally doctors have been asked to indicate on a Likert scale how satisfied they were with the consultation. Howie et al found both highest and lowest levels of dissatisfaction with consultations among the group of doctors that they designated least patient-centred depending upon the speed at which they consulted³⁴. Winefield and her colleagues compared doctor satisfaction with patient satisfaction and found they correlated poorly¹²⁰. They categorised consultations as straightforward, psychosocial or complex and found doctors were more satisfied with straightforward consultations and least satisfied with complex consultations^{vii}. Straightforward consultations were on the whole shorter than complex or psychosocial consultations and "medical clarity" was a feature of them. Doctors felt unsatisfied in complex consultations where there was a high level of patient

^{vii} Psychosocial consultations were those in which the only or major purpose of the consultation was to help the patient with stressful life events or psychological/psychiatric disturbance/illness or to provide information or advocacy to the patient at their request. In complex consultations the patient presented 3 or more apparently unrelated symptoms and /or tension was evident between doctor and patient in respect of assessment or management of problems All other consultations were designated straightforward.

involvement. It is difficult to understand the meaning of these evaluations however without more explicit reference to the experiences with which they are linked.

Conclusion

In this chapter I have suggested that three varying perspectives on the nature of the general practice consultation are evident in the writings about it: the consultation as a technical problem of practice; the consultation as patient-centred activity; and the consultation as a moral encounter. I have reviewed the literature that reflects these varying perspectives. Quite different views of the role and responsibilities of the general practitioner in the consultation underlie these perspectives. At one extreme the doctor is seen as the embodiment of a stock of clinical knowledge and skills which he deploys rationally in the interaction between himself and a patient. At the other extreme the doctor's personality and its expression is seen as intrinsically therapeutic and the source of his individual expertise.

In between these two perspectives lies the view of the patient as an experiencing individual whose subjectivity can be mediated by the patient-centred actions of the doctor in the consultation in such a way as to improve the patient's wellbeing. Indeed the view of the patient as an experiencing individual is central to general practice's claims to unique disciplinary identity.

A complementary view that sees the doctor also as an experiencing individual is somewhat under explored in the literature. Indeed research about the doctor in the consultation has tended to focus on how their individual attributes contribute to the nature and outcome of the interaction, rather than how the doctor experiences

the interaction in his own internal world. In other words the research has focused on objectifying the doctor rather than exploring his or her subjective experiences. As a result efforts to understand how the individuality of the doctor influences the consultation have been disappointing.

Explorations of doctors' experiences reported in the literature have tended to occur in the context of their management of patients with specific clinical conditions, and usually those conditions that present difficulties to doctors. Doctors' responses to everyday routine consultations have not been systematically explored. In this study I intend to explore how general practitioners experience satisfaction with a range of consultations by focusing on specific consultations, rather than on general practice as an abstraction. In the next chapter I describe the methodological considerations underlying the study I undertook and describe the way the study was conducted.

CHAPTER 3: METHOD – THEORY AND PRACTICE

Introduction

In the previous chapter I outlined the rationale for the present study by placing it in the context of the existing literature both about general medical practice in the UK and the general practice consultation more widely. I have suggested that three perspectives on the nature of the general practice consultation underlie this literature: the consultation as a technical problem of practice; the consultation as a medium for the expression of patient-centredness; and the consultation as a moral encounter. These perspectives in fact imply very different views of the role of the doctor in the consultation, from being an embodiment of objective knowledge and skills, to being intrinsically therapeutic through the deployment of their own personality (the drug doctor). What these perspectives on the consultation perhaps fail to acknowledge sufficiently is the emotional aspect of doctors' work in the consultation and the impact of this upon the doctor's internal world. In order to develop this perspective on the consultation, the aim of this study is to explore how general practitioners experience satisfaction with their everyday consultations.

In this chapter I intend to deal with two issues. First to detail some of the theoretical issues and methodological considerations that underlie the practical choice of methods, and second to go on to describe how the study was undertaken in practice. This latter objective will include discussion of the problems I encountered, the compromises I made, and the eventual process by which data was collected, collated and analysed including the instruments and techniques used.

Theoretical methodological considerations

During the time I was formulating and refining the overall research question, I was also making decisions about the method(s) I would employ to address the question. In any study, there is significant interplay between these two cognitive processes: not only do the research questions inform the choice of methods but also the chosen approach helps frame the research questions themselves. This was the case in this study. In qualitative research the methodological perspective is inextricably linked to the epistemological^{viii} standpoint of the researcher. This presents a problem for health professionals in using qualitative research methodology. Medical training does not involve much, if any, reflection on the epistemological basis of knowledge. Learning medicine is grounded precisely in establishing in which world knowledge is to be acquired⁹¹. It is taken for granted that biomedicine provides an objective scientific account of the human body and illness. Therefore it is rare for health professionals to come to a qualitative research project without an a priori view about what can be known. Indeed as Kathryn Montgomery Hunter points out the medical profession is somewhat pre-occupied with the gold standard of "science" in clinical practice exemplified by clinical trials¹²¹. Even my own discipline, general practice, which empirically acknowledges the contextual and cultural character of illness, is underpinned by fundamentally biomedical assumptions about the reality of the body and organic disease. This means that health professionals involved in qualitative research tend to use social science methods descriptively and rarely relate to social theory. As a result much qualitative research by health professionals is not explicitly linked to theory of any sort and as a result is unreflexive in respect of the beliefs and

^{viii} Epistemology is the branch of philosophy that deals with the varieties, grounds and validity of knowledge; and the relationship between the knower and what is known.

assumptions that have led to a particular line and way of questioning in the research.

I wished to avoid this theoretical vacuum and to engage with a theoretical perspective that might inform my work. However I equally wished to locate the thesis within the discourse about the discipline of general practice. I was therefore faced with a key choice. To engage unreservedly with social theory would render the thesis sociological in nature and as a practitioner I was keen that the thesis should be relevant and accessible to practising doctors. Therefore there are limits in the level to which I have engaged with social theory. Nevertheless, although this is a “general practice” thesis and not a social science thesis, my work has been informed by the tenets of constructionism and its proponents’ views on the nature of social reality. I have chosen this philosophical position on the basis of the task at hand, that is to investigate the way that general practitioners experience satisfaction with consultations. From the outset it seemed likely that the way general practitioners experience satisfaction in this facet of their work would be highly dependent upon the way the reality of that work was ‘constructed’.

Social constructionism

In 1967 Berger and Luckmann¹²² published their account of “The Social Construction of Reality”. In this they presented an analysis of knowledge in everyday life to support their theory of the social construction of reality. They conceptualised society as the product of a dialectical process between objective and subjective reality. Their standpoint gave rise to a particular form of “social” constructionism. There are a variety of other forms of constructionism whose proponents, in fact, adopt quite diverse perspectives. These perspectives are distinguished one from the other by the extent to which proponents accept the

existence of reality independent of its socially organised representations. However, broadly speaking, proponents of social constructionism reject the notion that the world is composed of objective facts and that there is one reality which can be identified and which exists independently of us. Rather proponents of social constructionism argue that multiple realities exist, and furthermore that these are socially constructed realities.

However there are problems with adopting this perspective uncritically. Perhaps the most common criticism levelled at social constructionism is its inherent relativism¹²³ which taken to extremes denies that there are any truths. In other words proponents acknowledge no reality independent of socially organised representations. This has serious consequences for researchers because the existence of multiple, competing realities renders accounts, in effect, unassailable. The consequences of this are what Atkinson and Hammersley¹²⁴ refer to as debilitating nihilism, which makes the business of research so problematic that it becomes fruitless.

Atkinson and others¹²⁵ have however rebutted this view by arguing that social constructionism does not imply that individuals “whimsically conjure reality out of thin air” or that reality is solely a mental or cognitive product of disembodied minds that have no engagement with a ‘real’ world. They argue instead that reality is produced through social processes by which actors engage with the material world, and that there is no problem in recognising that socially organised practices (such as, in the case of medicine, investigation, perception, description and manipulation) are transactions with and within a material universe. The general practice consultation is one such socially organised practice. Atkinson issues the caveat that equally there is no good reason to endorse the view that those transactions are totally governed and constrained by that material domain.

Hence to regard reality as the product of socially organised engagement with a “real” material world is consistent with a social constructionist perspective. Therefore it is possible to combine the search for knowledge about which we can be reasonably confident with a commitment to social constructionist thought¹²⁶.

Furthermore, researchers’ representations of reality are depictions of the social world arising from a particular perspective and these are constructed by each researcher’s interactions with the subjects of the research, that is they are constructed inter-subjectively^{ix} through communicative practices that are purposive and motivated acts. I will go on later to address the important question of my own professional identity in relation to this research and in so doing illustrate how the concept of inter-subjectivity applies to this piece of research.

The general practice consultation and the social construction of reality

The starting point for the study is the notion that the general practice consultation is a social act and not merely a technical problem of practice for the doctor^x. This means not only that the consultation is constituted jointly in interaction between the doctor and the patient rather than solely by the activities performed by the doctor, but also that it is socially constructed. The next section examines how the reality of the consultation is constructed so that it can be meaningfully experienced by its participants (in particular the doctor).

^{ix} Inter-subjectivity is the space where subjective reality is revealed.

^x Viewing the consultation as a technical problem of practice for the doctor assumes that the nature of the consultation is determined and constituted by the actions of the doctor and furthermore that these actions are contingent upon the doctors’ knowledge and clinical skills. As such the consultation is amenable to modification solely through remediation of the doctors’ knowledge and skills.

Social construction of the consultation

Peter Berger (with Hansfried Kellner) described the process by which a consistent reality is produced in relation to marriage¹²⁷. In doing so they examined in general terms the process that constructs, maintains, and modifies a consistent reality in respect of social relationships. Applying the essential components of the process they outlined to the general practice consultation reveals how the consultation is socially constructed. They state that every society has a specific way of defining and perceiving reality which is given by the language that forms the symbolic basis of society. In chapter 2, I outlined the prominent forms of discourse about general practice. These included generalism, continuity, patient-centredness, communication, holism and biopsychosocial models of illness, and these typifications are accepted and held in common by general practitioners. Moreover they have acquired the character of objectivity and are taken for granted. Thus the doctor is given a crucial set of cornerstones for his everyday experience and conduct in the consultation. Furthermore this pre-definition of criteria relevant to his everyday work allows the experience of this work to be shared with others and the conduct of that work to be mutually intelligible. Therefore the doctor-patient interaction within the general practice consultation is an act that is socially legitimated long before it takes place in an individual's life. Furthermore it is amplified by a pervasive ideology. Hence the way in which a doctor comes to perceive and define the consultation is not chosen by him but is ready made for him. Thus something of the reality of the work is constructed *for* doctors and patients by society. However Berger and Kellner highlight that the socially constructed world is continually mediated and actualised by the individual so it can become and remain his world. The doctor orders his world in the consultation through use of the specific stock of taken for granted knowledge, the relevance of which is pre-defined for him by society, but which he also organises according to

his own changing interests. In this way the doctor plays a part in constructing the reality of the consultation for himself.

Viewing the consultation from this perspective, this study seeks to understand how doctors experience satisfaction in consultations. Exploring the subjective experiences of the doctor in the consultation is crucial to understanding the conduct of their work. In particular this study seeks to provide insights into the way the socially constructed world of the consultation is mediated and actualised by individual doctors. It explores the meaning doctors ascribe to the processes and practices that occur within the consultation, the value they attach to them, and the impact these have on their evaluation of the experience of the consultation.

This overall approach to the evaluation of the consultation lends itself to the adoption of qualitative methods. The techniques associated with this approach produce contextual accounts that explore the meanings and significance for the participants of the processes and practices that take place. That is, the world of the subject is explored.

Choice of method

The choice of methods lay between adopting exclusively observational approaches, interviews alone, or a combination of observation and interviews. I decided upon the latter approach. I will now go on to outline the reasoning (theoretical and practical) behind that decision.

Observational methods

Very early in the process of considering the choice of methods for the study it became clear to me that observation alone would not generate the type of data I needed to address the question of how and why general practitioners experience satisfaction in consultations.

Observational approaches are usually divided into participant and non-participant techniques. Participant techniques require that the researcher has a role in the setting under study. In this study such an approach would have required me to be physically present in the consultation. Non-participant techniques involve the researcher witnessing events from a distance (physical or metaphorical). However in this study this distinction between participant and non-participant methods of observation seemed less than clear cut. For whilst indirect observation would not allow my physical presence in the consultation in question, I nevertheless share a body of experience and knowledge with the subjects which de-facto mimics my direct participation in the consultation. Therefore it could be argued, in this situation, that because of my "insider" status indirect observational methods share many of the attributes conventionally associated with direct observation.

Observation would allow me to detail the activities occurring in the consultation, describe technical aspects of the interaction between the two participants and understand the setting of the consultation. From my perspective the value of observation lay in the first two of these opportunities. The third seemed less useful to me as a practising general practitioner as I already had extensive personal experience of the setting.

Paradoxically, this personal experience seemed to present one of a number of practical obstacles to using observation alone as the method of choice, as the

premise on which observational methods are based is that the researcher learns about the setting and obtains the perspective of an outsider. I clearly had pre-existing knowledge of the setting and my own "insider" views of it. It therefore seemed untenable to believe that I could simultaneously act as an outsider. I will return to the issue of my "insider" status in this research later in this chapter.

A further practical problem of using observation alone was the effect any kind of observation has on the behaviour of the participants in the setting under investigation. The presence of an observer in a general practice consultation has the potential to change the way in which both doctor and patient behave, to change the dynamic of the interaction between doctor and patient and thus influence the feelings the participants have about the consultation. As the purpose of the research was to explore the meaning of consultations for the doctor I was keen to minimise any such interference. Observational studies of the doctor-patient consultation in primary care have tended to use audio or, more commonly, video-tape recording as the means of observation^{43;45}. Being observed in such a way might also be expected to alter the behaviour of participants in the consultation. However the little evidence that presently exists tends not to support this suggestion. One study that examined the effect of video-recording on the behaviour of doctors suggested that doctors' behaviour in a consultation is unaffected by the presence of a video camera¹²⁸. The effect of video recording upon the consultation behaviour of patients remains unexplored, although intuitively on occasions it might be expected to have a significant effect leading for example to non-disclosure of private and personal issues. However the views of patients whose consultations have been video-recorded suggest the process is of little consequence to them¹²⁹ and has no significant impact upon their satisfaction with the consultation¹³⁰. I will discuss the potential effect of recording of consultations upon participation in the research by patients and doctors later in this chapter

A more fundamental problem, than any potential effect of recording upon the behaviour of the participants, with using observational methods alone was its lack of ability to reveal the depth of doctors' experience of the consultation or the meanings they attach to that experience. This last problem represented a significant difficulty. Using observational approaches alone would have required me to infer doctors' experiences from their observed behaviour. However having done this I could not have adjudicated on the meaning of these experiences and because of this I concluded that observational approaches alone would not constitute an appropriate choice of methods although observation clearly had some potential value. I was then led to consider the appropriateness of interviews as an approach to data collection in this study.

Qualitative interviewing

The purpose of conducting a qualitative interview is to allow the respondent to reveal his or her views and perspectives on the subject under investigation, in contrast to observational techniques where the subjects' experiences are inferred by the researcher from their behaviour. The structure of the qualitative interview, in which the discussion is guided using a topic guide rather than specific fixed questions, facilitates the respondent in "telling their story" in their own words¹³¹. In consequence a wide-ranging discussion is promoted in which complex issues can be probed and responses clarified and the "insider's perspective" shared.

The advantages of this approach are that it is possible to gain access to individuals' accounts of experiences and to the meanings that individuals assign to events and experiences. The respondents are able to challenge the researcher's preconceptions about what is important or significant about the objects of the

research. The interview process allows the complexities of individuals' attitudes and behaviours to become apparent. As McCracken¹³² said:

"The method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can also take us into the life world of the individual to see the content and pattern of daily experience"

Interview data: its strengths and limitations

The status of interview data has been laid open to much scrutiny. Seale¹³³ identified two major perspectives: one which regards interview data as reflecting the interviewee's reality outside the interview, and the second which sees interview data as reflecting a reality *jointly* constructed by the interviewee and interviewer. The former approach is at odds with a constructionist perspective because it does not recognise the inherently social nature of the interview itself and in turn treats interview data as unproblematic representations of interviewees' external reality. The latter approach embraces the idea that the interview is a purposive social interaction between interviewer and subject and that data generation is a *joint* accomplishment of interviewer and interviewee. This mutual participation in the interview process means that the research technique of the interview cannot be disconnected from the social encounter in which it is operationalised.

The interview is a *specific* form of social interaction. Both participants in the process have taken for granted knowledge about what the interview is, that is its nature, and the form it should take, even if this taken for granted knowledge may not necessarily be shared. Nevertheless both participants abide by tacit rules about the conduct of the interaction and adopt appropriate roles. For example, even though a qualitative interview is sometimes described as a "seemingly natural

conversation”¹³¹, it is in fact quite unnatural in that one speaker is primarily the interrogator and the other the interrogated. The interviewer therefore adopts the role of questioner and the interviewee the role as answerer. Furthermore the interviewer is likely to adopt the role of neutral facilitative interviewer to abide by the ‘rule’ of qualitative interviewing that says respondents should be encouraged to talk in a non-directive way¹³⁴. However the subject matter and issues invoked by interviewers’ questions, no matter how open they are, are central to producing interviewees’ talk, that is the topics and issues they invoke and the identities they speak from. Therefore the interviewer is actively collaborating with the interviewee to produce the interviewee’s account. These rules and roles influence both the form and content of the interview. This casts doubt on the reliability of the interview as a method to collect data about external reality.

In fact within an in-depth interview both respondent and interviewer, and not just respondent, are actively engaged in the construction of intelligible accounts that shed light on the experience under investigation. That is the meanings attributed to experiences during the discussion are constituted through conversational practices that involve negotiation and legitimation not only of the form of the interaction but also of the nature of significant terms within it. The accounts that are produced are grounded within the context of the interview. They draw upon retrospective understanding of events and experiences, in the context of the present. The present is constituted by the social act of the interview. Hence the account is not neutral, but it is constructed by the respondent in response to the need to present himself or herself within the interview as legitimate. In this case it is possible that interview data does not give insight into unique human experiences but rather rehearses ways in which it is considered appropriate to account for events and experiences. That is to say interviewees offer public rather than private accounts of their experiences¹³⁵. Furthermore respondents’ assumptions about the

relevance and adequacy of their response within the context of the interview can shape the content and nuance of their accounts. Hence the interview, as a social interaction, is an opportunity for the interviewee to engage in what Goffman¹³⁶ described as impression management, that is to present an idealised view of himself or herself in relation to the topic of the interview. In her study of peoples' attitudes to health, illness and medical care Cornwell¹³⁵ found it was only after people were interviewed repeatedly over several months that they revealed their true feelings and beliefs to the interviewer.

This critique of the status of qualitative interviews suggest that that they are rather more likely to generate accounts that epitomise officially accredited values than to reflect interviewees' everyday behaviour. In this study where the topic of the interview is satisfaction in consultations the interviewees' accounts may typify the professional rhetoric about, for example, communication rather more than their actual behaviour in the consultation does.

My position in relation to the data is a pragmatic one: whilst interviews cannot be treated as giving straightforward access to respondents' experiences, the doctors' narratives are nevertheless portrayals of the consultations under discussion. This does not deny that their accounts are constituted and reconstituted by them for presentation but accepts that they arise out of the experiences they depict. The portrayals are configured by the context within which the accounts are produced and as Rapley points out¹³⁷, when analysing data from interview talk, we must be aware of *how* the talk is locally produced by both the interviewee and interviewer. This requires sensitivity to the context of the interview. Important aspects of this context include both the physical setting in which the research takes place -which I will return to later in this chapter- and the relationship between interviewee and

interviewer. Furthermore relating the data to the circumstances of their production is imperative in analysis.

As Melia says of interview data:¹³¹

“Informal interview data are yielded by a series of questions and general lines of enquiry embedded in a seemingly natural conversation with the interviewee. The data can be seen then as an account of the interviewee’s opinions and views arrived at as a result of interaction with the researcher. The effect of this interaction cannot be denied.”

Indeed this reflexivity about the research process is one of the things that gives qualitative research its analytic and explanatory strength. This leads me to consider my own status in the interviews^{xi} in this study and how this might have influenced the relationship in the interviews between the interviewee and myself.

The relationship between researcher and respondent

The process of the interview is interpersonal and dynamic and the perceptions of both interviewer and interviewee about each other shape the social relationship in the interview. Furthermore the data obtained in qualitative interviews reflect the social relationships embedded in the interview. Therefore it is important to consider the effect of my perceived characteristics, including my professional identity, upon the nature of the interviews I conducted and the data I gathered.

^{xi} The general question of where a researcher stands in relation to his or her data is a longstanding source of debate in qualitative inquiry. Feminist writers in particular have stressed that researchers’ own experience and interests can influence their research at every stage from conception of the research idea through data collection and analysis to dissemination of findings. This is a fundamental issue in this study and is crucial to the conduct of this research.

Until recently within the field of primary care research the issue of the respondents' perceptions of the researcher has been largely addressed in relation to researchers interviewing patients or lay people about health related matters^{138;139}. Only lately has there been interest in the nature of the interaction when doctors interview doctors about their work¹⁴⁰. In this literature the professional background of researchers has been identified as an important influence upon social relationships within interviews. Richards and Emslie¹³⁸ identified how their differing professional roles, general practitioner and sociologist respectively, led to interactions of differing nature within the interviews. The general practitioner interviewer was more obviously defined by her professional role than the sociologist. This perception impacted upon the type of data collected. Hoddinott, herself a general practitioner, experimented with how she revealed herself to patient respondents, either as a doctor or as a researcher¹³⁹. The data she gathered varied depending upon the characteristics she ascribed to herself. In relation to interviewing patients she was of the opinion that she collected "better" data when patients were aware of her medical status. This adjudication on the quality of data is probably unjustified. What is clear is that she will have obtained different data because, as I have argued earlier, the data obtained in any interview is highly dependent on the local context in which it is produced. The local context is configured in part through the talk and concomitant identity work the interviewee and interviewer do in the interaction.

So there is a general acceptance that "who you are affects what you get told". However who "you are" is not immutable but is dynamic and constructed in social relationships. In this study I was clear with respondents about who I was. My identity as a practising general practitioner was explicit, as was my role as an academic member of staff in a university department of general practice. However the interactions between the respondents and myself were far from identical. It was

apparent to me that it was how I was perceived by respondents that affected the interactions in the interviews. In other words it was “who respondents thought I was” that affected what I was told. My perception was that I was seen differently by different respondents. A similar observation was made by Chew Graham et al in their exploration of the benefits and problems attending the dual role as clinician/interviewer¹⁴⁰. In their research the general practitioner interviewer was variously viewed as researcher, expert, judge, peer and confidant. In the following section I intend to characterise some of the interactions in my interviews and consider what they might reveal about how I was seen by respondents.

Affiliation as characteristic of interaction

This was the most common type of interaction I experienced. When I was introduced to practice staff, who as I will describe were important to me in helping secure co-operation from patients, it was always as a *doctor* from the university. This identified me as someone with whom they could readily associate and who shared membership of the primary care community with them. In this way respondents affiliated themselves with me or affiliated me with them. In the interviews, as a general practitioner talking to another general practitioner, respondents saw me as a professional peer and therefore assumed that I had similar experience(s) to them and maybe that I held similar opinions to them. This assumed commonality of experience and opinions facilitated the research process, in particular it had the effect of equalising the status we both held whilst participating in the interview. Respondents generally felt “safe” in the process, probably because they perceived that I was likely not only to be sympathetic and empathetic to their perspective but also to share and understand it. As a result respondents were often willing to be quite open about their feelings about

consultations and individual patients, and sometimes divulged quite sensitive information. It is also possible that they trusted me not to misrepresent their views. We spoke the same language and sometimes this led to me taking for granted some of the things that were said because I felt intuitively that I understood the meaning of what the respondent was trying to convey^{xii}. One consequence of this is a blurring of the boundaries between researcher and researched and I was aware of this happening in some interviews where respondents sought to elicit my perspective on the subject under discussion by engaging with my own experiences as a practising general practitioner. This was not a deliberate or conscious attempt to subvert the research process but perhaps a consequence of the way doctors naturally compare “cases” in conversation with each other. Furthermore, in general practice it is unusual for doctors to have their work directly observed by a peer and the opportunity to discuss their work in the way encouraged in the interview rarely occurs.

In some interviews I was aware of consciously reshaping the boundaries between the respondent and myself. Without necessarily explicitly saying so I was keen to indicate that my own opinions and views were of little importance here. This often involved not responding to verbal and, in particular, non verbal cues to reciprocate in discussion with thoughts about my own clinical work or my observations on the interviewees’ clinical work.

^{xii} This situation is analogous to, for example, that of feminist researchers interviewing women where they have either assumed or sought common cause with the subjects.

Circumspection

Less commonly the interaction in the interview was characterised by a degree of wariness. In this instance despite professional commonalities I was more clearly identified with the academic community rather than the service community. I was seen not as peer but as an assessor and was perceived by respondents as having a status that was different to their own. They did not take for granted that I would be sympathetic to their perspective insofar as they regarded the research process as one that might potentially evaluate them. This circumspection was manifest in interviews when respondents felt the need to defend their actions in a consultation. This generally arose out a mistaken belief that I was evaluating the consultations I recorded. Therefore they perceived a need to interpret their emotive responses to consultations in such a way as to portray themselves and their actions favourably. These perceptions of me as assessor could perhaps be traced back to the high profile locally of the department of general practice's research into quality in general practice. They also make explicit the issue of power relations in the encounter. If the respondent's view of the research process is one through which surveillance of their practice occurs, then they are likely to be cautious about revealing views and opinions that are at variance with prevailing professional rhetoric. Here my status is not as an insider. Sometimes as the interview progressed and it became clear that this was not my intention, this characteristic of the interaction changed and I perceived my identity was re-constructed by respondents.

Interviews characterised by circumspection tended to be pervaded by a lack of rapport in the interaction. Consequently they were less successful in accessing doctors' private accounts of the experience of consultations and relied on a more technical discourse about practice. Moreover in these, relatively few, interviews I

sensed resistance from the interviewee when I tried to pursue more private accounts. This left me feeling uncomfortable and wary of causing offence.

Characteristics of the data I obtained

It is likely that my personal characteristics other than my professional role, for example relatively young white female, also had an impact on the nature of the interaction between the interviewee and myself. In other circumstances their impact might have been more obvious. In this study I feel they were, by and large, eclipsed by my professional role.

It is likely therefore that I obtained systematically different information from the interviews than a non-doctor researcher might have done. That is not to suggest that this information is necessarily better or worse just that it is different. To quote Anspach¹⁴¹,

“Rarely do doctors directly reveal their assumptions about patients when talking to them; it is in talking and writing to other doctors about patients that cultural assumptions, beliefs and values are displayed more directly”

Furthermore interaction between two doctors might be expected to produce data that reflects the type of specific medical discourse which is common when doctors talk to each other about patients¹²¹.

Thus my status as a member of the general practitioner group has potential disadvantages in the research process. My “being native” means it is almost inevitable that I will identify, at least to some degree, with the perspectives of the respondent general practitioners. This becomes a credibility issue for the research if as a consequence I fail to treat the respondents’ perspectives as in any way

problematic. In the early stages of the research this was sometimes the case. For example, as I will discuss later, respondents routinely alluded to how well they knew patients in their accounts. At the beginning I tended to take this statement for granted because it is commonplace in general practitioners' talk about their work generally. However to have failed to interrogate this concept in later interviews and subsequent analysis would have resulted in a serious deficiency in the research.

To conclude, as I am a general practitioner there is clearly a great deal of taken for granted knowledge between myself as interviewer and the interviewees in this study. Whilst in some circumstances this might be regarded as a methodological problem, in this case, I suggest it is in part responsible for me being able to obtain the doctors' accounts, particularly those private aspects of the accounts that reveal their feelings and beliefs.

Undertaking the study

I will now move on to outline the conduct of the study, highlighting the issues and problems I encountered in so doing, and describing the processes by which data was eventually collected and analysed.

Recruitment of general practitioner subjects

The study setting was restricted to Lothian region in Scotland. This was a pragmatic decision. Including doctors working in other areas of the UK in the study would have added immensely to the costs of the study and to the time required for data collection and made it almost impossible for me to carry out the research within the context of my present employment. So the choice of setting

boiled down to doing the research in Lothian or not doing it at all. Moreover general practitioners in Lothian are a heterogenous group working in varying settings.

The recruitment of general practitioners to the study was the most problematic part of the exercise. My intention was to generate a diverse sample of general practitioners which as far as possible represented the population of general practitioners in Lothian. Consideration of my sampling strategy followed. My first thoughts were to sample general practitioners randomly. The rationale behind such probabilistic sampling is that it generates a sample representative of the whole population from which the sample is drawn. However there are in excess of 500 general practitioners in Lothian, and the proposed sample for this study was to be between 15 and 20 general practitioners. Given the large ratio of doctors in the study population to doctors studied it is possible that random sampling would not have resulted as hoped in a representative sample, but in fact in a decidedly biased one. Furthermore the strength of probabilistic sampling in analysis of data is that it allows statistical generalisation to the population studied. In this study there was no intention to generalise statistically to the general practitioner population.

An alternative sampling strategy, that of purposive sampling was therefore more appropriate on both theoretical and practical grounds. In order to generate a well-structured sample of general practitioners with maximum variation practitioners with specific characteristics were identified. I selected 15 doctors from the list of general practitioners in Lothian and invited them by letter to participate in the study. A reply slip was enclosed with the invitation letter. This offered them the choice of replying positively or negatively to the invitation. Of the initial fifteen invitees, six replied: five declining the invitation and one accepting. Six weeks after the initial letter follow up letters were sent to the nine practitioners who had not

replied offering a telephone or face to face meeting to discuss their possible involvement in the study. None responded to this second approach.

The failure of my initial recruitment strategy led to re-consideration of the way I invited practitioners to participate. I was aware of the large volume of written requests doctors receive requesting their help with research and I therefore decided to employ a more personal approach. I identified a further sample of general practitioners encompassing a wide range of characteristics for example age, sex, seniority, partnership status, past professional experiences, professional interests outside their practice such as involvement in academic work, training and service delivery. Knowledge of their characteristics was derived from, personal knowledge, personal communication with colleagues, and from data in the public domain. I approached each of the identified subjects personally by telephone to establish their possible interest in the project and to arrange a meeting to discuss more fully with them their participation. This personal approach proved more successful in recruiting subjects with doctors rarely declining involvement. The fact I am a general practitioner myself appeared to optimise general practitioner recruitment. Many agreed to participate despite competing claims on their time, and I perceived that many did so as a professional favour to a colleague.

The meeting between myself and each participating doctor took place face to face usually in the practitioner's surgery. At some point during this meeting I also usually met with the senior receptionist or practice manager to discuss the requirements of them during the period of data collection. These were modest but involved them directing those patients attending a surgery at which recordings were being made to speak to me prior to seeing the doctor.

General practitioner sample

Nineteen general practitioners took part in the study. By design they were a diverse group. Nine were female; ten were male. They were all white British. They had been practising as general practitioners for between 2 and 29 years and their ages ranged from 30 to 55 years. One doctor worked single-handedly, the rest worked in group practices with between 2 and 9 doctors. Sixteen of the nineteen doctors were partners in the practices in which they worked. The remaining three doctors were assistants. Fifteen of the doctors worked full time. Four of the doctors were postgraduate general practitioner trainers; two were regional advisors. Two doctors had academic appointments. One doctor was a local health care co-operative medical director. Only one of the doctors had worked permanently post vocational training in a practice other than the one they were in now. The practices were in areas ranging from high socio-economic disadvantage to affluence.

Among the eighteen doctors working in group practices only one worked in a practice claiming to operate personal lists. This is a system whereby although the doctors work in a partnership, they personally provide care to the patients on their registered list. Patients are therefore discouraged from consulting with other doctors in the practice. In contrast in group practices care for the practice's registered patients is regarded as a collective responsibility. Hence patients are able to see the doctor of their choice on any occasion, although within this practices vary in the extent to which they encourage the continuity of an ongoing doctor-patient relationship.

Design of study

The study comprised 2 phases of data collection:

1. audio-recording of consultations and collection of quantitative data about consultations; and
2. qualitative interviews with general practitioners based on selected recorded consultations.

Ethical approval for the study was obtained from Lothian local research ethics committee.

Data collection - Recording of consultations

Recruitment of patient subjects

I intended to record 30 consecutive consultations with consenting patients for each doctor. In reality this proved difficult. The main reason for this was that within my job I had limited protected time for conducting this study^{xiii}. Consequently I had to fit data collection in around fulfilling other commitments. This meant that I was never available to conduct the data collection for 30 consecutive patients. As a compromise participating doctors and myself identified 3 mutually convenient surgeries to record. These surgeries were as close together as practicable given the constraints of time. Surgeries that were already being observed, for example by a medical student or a general practitioner registrar, were excluded from the study. Special clinics held within the practice, for example asthma clinics, diabetic clinics and well woman clinics were also excluded

^{xiii} I am employed by the University of Edinburgh as a clinical lecturer in general practice. I have clinical, teaching and administrative responsibilities in addition to research commitments.

Patients were recruited on the day of the recorded surgeries when they presented for their appointment. Until this point they were quite likely to be unaware that the doctor they were seeing was taking part in a research project although a notice was posted in the waiting room to this effect. The receptionist asked each patient to make themselves known to me when they booked in. The receptionists explained to the patients I was a researcher but gave them no other details of the project. A small number of patients failed to make themselves known to me at this stage and occasionally receptionists forgot to direct them to do so. These omissions only became known to me when the doctor called the patient. No attempt was made at this point to obtain consent from the patient for the study and they were not included. The reason for this was that I was keen that the research process should have as little effect as possible on the context of the surgery for the doctor and the patient. In particular I was anxious that the study should not per se cause doctors to run late because of the known effects of this on practitioner stress⁷⁰ and the possible consequent impact on satisfaction. In the later stages of data collection I asked the participating doctor if I could have a copy of their surgery list for the day. This minimised occasions on which patients slipped through the recruitment net.

To recruit the patients I sat in the waiting room. This had obvious disadvantages in terms of privacy but the practicalities of space in most of the practice premises meant there was no alternative. When patients made themselves known to me I explained the purpose of the research to them, describing what their involvement would be and asking for their consent to audio-record their consultation. In the case of the patient being a child under 16 their parent or guardian was asked for consent to record the consultation. The number of patients declining consent was small. I asked for no explanation from those who declined but those declining often

volunteered a reason, the most common being that they had something personal or private to discuss with the doctor ^{xiv}.

Method of recording consultations

One of the decisions I had to make in relation to data collection was which method for recording consultations to use. The choice lay between audio-recording and video-recording. In making this choice I considered the purpose of the recordings in the research and the potential effect of the recording on the consultations under study. The prevailing trend in general practice training, education and research is to video-record consultations. As I described earlier in this chapter to date there is no evidence to suggest that video-recording has any objective effect on the consultation behaviour of doctors or that it makes any appreciable difference to patients. I could find no evidence of the effect of audio-recording of consultations on doctors and patients but I felt that there was no reason to think this would be significantly greater than the effect of video-recording. In this research the purpose of the recording was not primarily to describe or quantify the behaviour of patient and doctor in the consultation but to provide a record of the consultation. This record would allow me as the researcher to share something of the experience of the consultation, and help generate information about the doctor's views of the consultation in discussion in the qualitative interviews. It seemed to me that both audio and video-recording could fulfil these purposes equally well. Rarely doctors commented in the interviews that video-recording might have provided me with additional insights into specific consultations. In addition I was keen that the

^{xiv} Recent research governance instructions suggest that advance consent should be obtained. The fieldwork for this study took place before these directives came into effect and the Lothian local research ethics committee required only that a notice be displayed in the participating doctors' waiting rooms informing patients that the study was being conducted.

method of recording should result in as few patients as possible declining consent as I was eager that recorded consultations should be as representative as possible of the spectrum of everyday work in general practice. Most studies using video recording of consultations have reported consent rates of more than 80%. Studies in which formal written consent has been obtained by a researcher who is not a member of practice staff¹⁴²⁻¹⁴⁴ have reported lower consent rates than studies where general practitioners or practice staff have sought consent (sometimes verbal) immediately prior to the consultation^{130,145,146}.

Patients who withhold consent to video-recording are more likely than others to be younger, present overtly with a psychosocial problem or a mental health problem or be distressed or embarrassed. In my judgement audio-recording was likely to be seen by the patient as less intrusive upon their privacy and anonymity and therefore result in fewer refusals. This assumption was borne out anecdotally during data collection when a number of patients who were initially dubious about their consultation being recorded consented once they realised that audio and not video-recording was involved.

Despite the empirical evidence in the literature that recording of consultations has no significant effect upon the behaviour of the doctor in the consultation or on the outcome of the consultation for the patient, doctors felt subjectively on occasion that the research process impacted upon the consultation process. Indeed authors have contended that research activity *inevitably* shapes and constitutes the object of its enquiry¹⁴⁷. In the present study the "object of enquiry" was both the consultation between doctor and patient and the doctor's view of this. In relation to the consultation itself it is in fact possible that the recording of the consultation had an impact upon the behaviour of both doctor and patient in the interaction. Some of my general practitioner respondents commented in their interviews that

they felt, on occasion, patients had behaved differently from normal as a result of their participation in the study. For example:

“ I actually felt that probably the fact that he was taking part in the study and he was being recorded changed his way of dealing with the consultation because I felt he was giving me the third degree as if he was testing me out...He came in saying something like ‘ You’re under the spotlight today’. He maybe even thought I was being tested for being unsatisfactory or something (laughing).” (GP12)

This deviation from the expected behaviour of the patient was discomforting for the doctor and may have contributed to feelings of dissatisfaction. Doctors also commented that they themselves were aware of the presence of the tape recorder from time to time. Their attention was drawn to the presence of the tape recorder particularly in instances when they were dubious about their actions in the consultation. For example this doctor is reflecting upon a consultation in which she had not been able to ‘name’ a rash:

“I was very conscious of the tape recorder. I was kind of wittering because the rash didn’t look like anything spectacular.” (GP3)

However the impact of the research process was mentioned only infrequently by doctors and while it probably impacted subtly on many consultations, it probably only rarely had a profound effect.

Consultation data

Once the patient had signed the consent for the recording of their consultation they kept hold of the consent form so that the doctor would be aware they had agreed to recording when they entered the consulting room. The doctor then

switched the audio tape recorder on. For each recorded consultation doctors noted the following information:

- the appointment time for the consultation,
- the times the consultation started and finished,
- the tape counter numbers at the start and end of the consultation.
- age of patient
- sex of patient

At the end of each consultation, the doctors scored the consultation according to how satisfying they had found it on a scale of 0 – 10, where a score of 0 was maximally dissatisfying and a score of 10 was maximally satisfying. Doctors were instructed to score the consultation according to their “gut feeling” and not to try to rationally evaluate the consultation. The intention was to try to access the doctor’s emotive response to the consultation and to try to minimise the effect of post-hoc rationalisation.

Data collection – in depth interviews

Within a few days of the conclusion of recording for each doctor I listened carefully to the audio-tape recordings. For each general practitioner the two most satisfying consultations, the two least satisfying consultations, and two other consultations randomly selected from those recorded by each doctor were identified. Where a group of more than two consultations were equally satisfying or dissatisfying, two were selected randomly from the group. For each doctor I made notes on the content of these six consultations which formed the basis of the second phase of data collection. This second phase comprised in depth interviews conducted with each doctor within one week of the completion of their audio-recording.

The setting of the interview

The interviews took place as soon as practicable after the completion of the recording. It was my intention that all interviews should take place within one week of the end of recording so that the doctors would have a clear recall of the consultations, and in the majority of cases this proved possible. However on two occasions the interviews were conducted ten days later. The majority of interviews took place at the doctor's surgery usually during their working day but on five occasions other venues proved more convenient and so these interviews were conducted in my home or in the Department of General Practice. At the time of arranging the interviews I indicated to the doctors that the interviews would take around about one hour. Respondents usually set aside this amount of time for the interview. Respondents were careful, generally to reduce interruptions during this hour to a minimum. However there were occasions on which the interview was punctuated by telephone calls, and requests from receptionists, and on one occasion the start of the interview was delayed by an urgent house call. The extent to which the respondents prioritised the research and made alternative arrangements to cover their commitments during the interview might indicate what level of engagement they had with research generally and with this study in particular. Interviews which took place at the university or at my home were considerably less susceptible to these distractions.

The interviews

The participating doctor and myself had generally become reasonably acquainted during the period of recording of consultations. Nevertheless it was still important for me to gain their confidence for the interview. The doctors often had some qualms about the interview, which were related mainly to the fact they perceived

that through the recordings they had exposed their practice to the scrutiny of a peer. I was careful to reassure them that in the interviews I was not asking them to explain or justify their behaviour or performance in the consultations but rather I was seeking to understand why they had felt as they did about it. The extent to which this reassurance was effective varied. Occasionally interviewees would justify an action they perceived I might regard as inappropriate or seek my professional view on their behaviour or decisions. I have discussed the issue of the inter-subjectivity of the interviews previously in this chapter.

At the start of each interview I thanked each doctor for agreeing to participate in the study and for their co-operation thus far in recording their consultations and collecting the data about them. I then went on to give the doctor a brief explanation of the structure and format of the interview. The first part of the interview sought to establish some details about the doctor and their career. From then on the interviews were loosely structured around the selected consultations. No interviewee objected to me audio recording the interview, which I did using a Genexxa Micro -17 micro cassette recorder and tapes.

Interview topic guide

I decided against developing a formal interview schedule. The intention of the interview was to allow the interviewees to display their way of understanding their own consultations. I did not think that fixed questions in a predetermined order would best allow this. Moreover as the interviews were based around doctors' individual experiences the questions that would best elucidate this understanding for one individual would be ineffective for others. Instead a topic guide was developed for the interviews. The topic guide included the issues I wished to address with each interviewee. However I used it flexibly so that interesting or new

aspects of accounts from respondents could be followed up and explored further. When aspects of accounts recurred in a number of interviews these were then incorporated into the topic guide for later interviews. For example it became clear early in the series of interviewees that doctors referred routinely to the extent to which they felt they knew a patient. In later interviews when this was mentioned the meaning of this concept was explored more fully. The topic guide included:

- general details about the doctor and their career including their particular areas of interest;
- accounts of the content of selected consultations;
- the doctor's feelings about each selected consultation;
- explanations for their feelings;
- possibilities for enhanced satisfaction;
- constraints on satisfaction with selected consultations; and
- personal attributes influencing satisfaction.

The first part of each interview was the most structured concentrating as it did on factual information about the doctor's career and current work. It then developed into a much more fluid encounter with an iterative format in which we discussed each of the six selected consultations in turn and where appropriate comparisons were made between selected consultations. The topic guide items were broadly covered for each of the selected consultations.

Transcription and data preparation

Interviews were transcribed verbatim in batches of 2 or 3 throughout the data collection period. A secretary produced the first draft of each interview transcript. I then checked this transcript myself against the tape and made the necessary

corrections. Often a number of corrections were required. These related in the main to technical aspects of the discussion between the interviewee and myself. This highlighted the extent to which we shared a common professional language. Verbatim transcripts were then edited to remove irrelevant conversational material and create a final comprehensible transcript. Care was taken not to alter the sense of the doctor's account in any way during this process.

Data Analysis

Constant comparative method

Analysis of the qualitative interview data was governed by the broad precepts of constant comparative analysis. Glaser and Strauss described this technique as being central to their grounded theory approach to qualitative research¹⁴⁸. However it has been deployed in analysis in a number of studies, some exploring doctors' perspectives on their work with patients with particular conditions^{105, 108} in the absence of other cardinal features of a grounded theory approach. This was the context in which it was used in this study. The rationale for this approach follows. The method of grounded theory requires that the researcher begins only with an area of study and that concepts and hypotheses relevant to it are allowed to emerge from the data. The researcher does not begin with a theory and then test it. Grounded theory has had a somewhat chequered history. Strauss and Corbin refined the original grounded theory method in 1990¹⁴⁹. However this modification met with criticism from Glaser who considered that it inappropriately involved a forcing of data and a preconceived and verificational approach to qualitative data analysis that was incompatible with the most important ideas in the original version of the method. In this study there are compelling reasons not to have

employed a grounded theory approach. Given that I was exploring doctors' satisfaction with consultations similar to the ones I routinely experienced in my own clinical practice, it did not seem a sustainable position to suggest I had no preconceived ideas about the area of study. I simply could not be blind to my own experience.

However the broad precepts of constant comparison were followed in terms of the strategies for data gathering and analysis. In particular, I constantly moved between the two activities of data gathering and analysis. That is broadly speaking data collection and analysis of the data took place in parallel. This process allowed me to refine my data collection in the later interviews to follow up leads that had emerged from preliminary analysis of earlier interviews. Furthermore the analytic process was focussed around the development of explanatory propositions about how and why general practitioners derived satisfaction from their consultations rather than the testing of pre-existing hypotheses. Doctors' accounts of consultations were coded into a number of categories. For example the category "knowing the patient" was constructed. Excerpts from transcripts with the same code were photocopied and examined to compare them and identify properties of the category. For example comparing consultations in which the doctor talked about knowing the patient revealed properties of this category, for example "what is known" "who is known" "how they are known" "the effect of knowing". A further category was apparent in the data and was concerned with the doctor "evaluating the patient". The properties of this category included "what evaluations are evident" "how are they made" and "what is their purpose". It then became clear that integrating the two categories provided the beginning of an explanation of how doctors' perceptions and knowledge of patients might impact upon their satisfaction with consultations.

Theoretical sensitivity

The analysis of the data in this study was intended to go beyond description into interpretation. The purpose was to construct an in-depth representation of the way general practitioners attribute meaning to their work on the basis of detailed knowledge about specific cases. In order to do this the process of analysis involved what Ragin called "data enhancement"¹⁵⁰. In other words the ideas that arose out of the data were developed and expanded in the course of analysis. This process is unique because it involved a significant degree of interaction between my own experiences and knowledge, the research setting and the data itself. This is the basis of what Glaser and Strauss called the researcher's theoretical sensitivity. By this they meant the researcher's ability to conceptualise and formulate a theory as it emerges from the data. It is based upon the researcher's own "personal and temperamental bent" and "ability to have theoretical insights into his area of research, combined with an ability to make something of his insights"¹⁴⁸. Strauss and Corbin¹⁴⁹ also described the importance of theoretical sensitivity which they state derives from knowledge of the literature on the subject under study and the professional and personal experience which a researcher brings to the analysis.

In my own clinical practice I have experienced satisfying and unsatisfying consultations. Whilst I have not formally investigated these experiences I have developed through them a tacit understanding of my own work as a general practitioner. This understanding provided a powerful context for the investigation I undertook in this study, influencing not only its conception, but also the creation and interpretation of data. For example one fundamental assumption of this research is that practitioners actually do experience some consultations as qualitatively more satisfying than other consultations - a supposition supported primarily by my own experience and my informal conversations with colleagues. With respect to the creation of data in this study, the way in which I have made

sense of my own experiences in consultations influenced the aspects of interviewees' accounts upon which I encouraged them to expand in interviews, and inevitably affected the character of the data produced.

Similarly in terms of my analysis it is inescapable that my role as a general practitioner shaped the way I interrogated the data. The thematic analysis which preceded the more interpretative phase of analysis was influenced by my familiarity with the conceptual literature about the general practice consultation and this encouraged me to look, for example, for discussion of technical endeavour and for references to patient centredness within interviewees' accounts. The interpretative phase of the analysis involved re-creation of the data through development and expansion of the ideas evident within the thematic analysis. This enhancement of the data occurred in the context of my own knowledge and experiences and therefore the eventual interpretation of the experience of consultations presented in this thesis is the product of a unique interaction between my own subjectivity and the data itself.

My personal professional experience also had the potential to overly affect my interpretation of the data if my own assumptions about the subject under study unduly influenced my interpretation of the data or if I shared uncritically the assumptions upon which the data was founded. As a safeguard against this, the process of data analysis included repeated reflection on the "fit" between my emerging explanatory propositions and the in-vivo data and sensitivity to the way in which my own a priori assumptions might shape my analysis. This involved repeatedly checking out categories, explanations and hypotheses against the data and abandoning those that did not stand up to scrutiny irrespective of my own pre-conceptions.

Ethical problems in the presentation of qualitative data

Verbatim extracts from transcripts are used extensively in subsequent chapters of this thesis to illustrate the findings of the study and to support the discussion of the results. Such use of data is commonplace in qualitative research since the respondent's own words often offer powerful vindication of the analysis and allow readers to discern how the conclusions drawn have arisen from the data collected. However use of respondents own words is not devoid of ethical problems.

Prime amongst a researcher's ethical imperatives is to protect respondents' anonymity and confidentiality. In my approach to patients for their consent to audio-tape their consultation I gave an unequivocal assurance that the recording would be subject to the same level of confidentiality as medical notes, and that it would be kept in a locked cabinet until the conclusion of the research and thereafter destroyed. I similarly assured general practitioner respondents that the tape recordings of interviews would be held in absolute confidence and that they would not be identified in the thesis and in any work that might arise from it. These assurances however are not unproblematic. In research conducted in a circumscribed geographical area it might not always be possible to completely obscure the identity of doctors especially when they are discussing personal details which may be known to others. I have thus tried as much as possible not to present data that reveals the identity of respondents.

In this study my respondents were doctors, but their narratives also often revealed personal details about patients. All the patients consented to audio-tape recording of their consultation, and they were aware that their consultation would form the basis of a discussion between their doctor and myself. However it is clearly imperative that the presentation of data does not compromise the confidentiality of the patient. Therefore when presenting extracts from interviews I have changed the

names of patients and places. Clinical details however remain unchanged because they are relevant to the way that doctors talk about the consultations and to alter the nature of the problems patients presented would alter the context and sense of the accounts and make analysis meaningless.

One other issue of ethical importance when presenting qualitative data is the relationship between the presented extract and the data as a whole. The accounts are individualised and designed to reveal the unique perspective of each respondent. However the accounts together also reveal common themes and categories in the data. The use of extracts from accounts is to illustrate these analytic themes and to reveal how the explanatory propositions that are generated arise from them.

Summary

This chapter has covered two issues: the theoretical considerations underlying the methodological approach adopted in this study; and the way in which the study was undertaken in practice.

I have suggested that the experience of the general practice consultation for doctors, including the satisfaction they subsequently express, is likely to be highly dependent upon the way the reality of their work in the consultation is constructed. I have therefore suggested that the experience of the consultation can be interrogated from a social constructionist perspective. The rationale that underlies this approach has at its core the idea that the general practice consultation is more than a technical problem of practice for the doctor and that it is first and foremost also a social act.

I have described how the “reality” of the consultation is partly given to the doctor and the patient before the consultation actually takes place because there is a pervasive ideology of general practice that provides decisive cornerstones for their experience. However individuals mediate the experience of the consultation and therefore produce a reality that is their own.

I have suggested that this view of the consultation lends itself to the adoption of qualitative methods to explore the experience of doctors in consultations. I have described how qualitative interviews were chosen in order to access the depth of doctors’ experiences and the meanings they attach to their experiences. I have discussed the status of the interview data I have gathered and have suggested that

my professional status as a general practitioner has systematically influenced the nature of the data I have collected.

In the latter part of this chapter I have described how I undertook the study in practice. I have described the difficulties I encountered in recruiting general practitioners, the process by which I eventually collected data and the techniques I used in analysis. I have indicated how I took account of the theoretical considerations outlined in the first part of this chapter in the collection and analysis of the data.

I will now go on to present the findings of the study. Analysis of the data generated four broad themes which seemed to influence doctors' satisfaction with the experience of consultations: the doctor's evaluation of their performance, the doctor's moral evaluation of the patient, the doctor's sense of knowing the patient, and the doctor's knowledge of themselves. Each of these themes will be considered in turn in the next four chapters.

CHAPTER 4: FINDINGS – EVALUATING THE SELF

Introduction

In the previous two chapters of this thesis I have set up the analysis of the interview data that follows in this and subsequent chapters. Through the review of the empirical literature about the general practice consultation and the conceptual writings about the nature of general medical practice I have elucidated the way in which the institutional “reality” of the consultation has been produced. The theoretical considerations outlined in the methods chapter not only informed this perspective on the literature but also informed the analysis of interview data presented here. The data presented in this chapter focuses on the respondents’ reflections upon and evaluations of their performances in consultations.

The doctors who were interviewed routinely talked about the consultation in terms of their performance within it. Two aspects of performance were apparent in their accounts: their behaviour and actions within the conduct of the consultation; and the perceived accomplishments of their work in the consultation. Doctors seemed to judge their performance in each of these aspects against empirical standards. The result of this appraisal seemed to be important to the way doctors accounted for the experience of the consultation. It was conspicuous that doctors expect firstly that they should be competent, and secondly that they *can* be in some way successful in the consultation. Consultations in which they perceived success were by and large more satisfying than ones in which their achievements were indeterminate.

Basis of evaluation

It was clear the appraisal of competence and success, or otherwise, in consultations was based upon doctors' perceptions of the specific knowledge and expertise upon which their discipline-general medical practice-is founded. The character of this knowledge and expertise was very much taken for granted by respondents in their accounts, and this reflects the everyday, rather than esoteric, nature of the knowledge that underpins general practitioners' work. Furthermore the taken for granted nature of this knowledge highlights that it is to a large extent socially produced. In other words doctors are inculcated with a particular knowledge. This is acquired both in the specific contexts of the various phases of their medical education: undergraduate education; postgraduate vocational training for general practice; and ongoing professional development, and through their experience of working as a general practitioner in the United Kingdom, in the latter part of the 20th century. Furthermore this knowledge reveals what are currently regarded as the core activities in the accomplishment of medical work in general practice in the United Kingdom.

Roots of general practitioners' knowledge and expertise

Undergraduate medical education privileges an objectivist view of medicine⁹². Students learn about anatomy, physiology, biochemistry, pathology, pharmacology, and ultimately diseases in context stripped milieu. Undergraduate medical education for the most part embraces the model of biomedicine in which, to quote McWhinney in "A textbook of family medicine"¹⁵¹:

“Patients suffer from diseases which can be categorised in the same way as other natural phenomena. A disease can be viewed independently from the person who is suffering from it and from his or her social context. Mental and physical diseases can be considered separately. Each disease has a specific causal agent and it is a major objective of research to discover them. Given a certain level of host resistance, the occurrence of disease can be explained as a result of exposure to a pathogenic agent. The physician’s main task is to diagnose the disease and to describe a specific remedy aimed at removing the cause or relieving the symptoms. He or she uses the clinical method known as differential diagnosis. Diseases follow a defined clinical course subject to medical interventions. The physician is usually a detached neutral observer, whose effectiveness is independent of gender or beliefs. The patient is a passive and grateful recipient of care.”

Whilst most practitioners would not subscribe wholeheartedly to this version of medicine in which the practitioner is a detached observer¹⁵², it remains the dominant discourse in medical journals, evidence based guidelines and continuing medical education programmes.

The focus of postgraduate vocational training for general practice acts as a counterpoint to this view by emphasising the contextual nature of much illness. Indeed training for general practice emphasises the need to examine the “whole person” in his or her wider social context²⁰. Philosophically it regards illness as arising out of a complex interaction of biological, cultural and social factors. A further focus of vocational training is on learning about the general practice consultation and developing high grade consultation skills which enable this wider examination to be enacted.

Practical professional knowledge however is rarely gained through compliance with any formal curriculum. It is a complex phenomenon that is difficult to deconstruct into a set of component competencies¹⁵³. However it has been shown that doctors learn primarily through their own clinical experience of patients with differing conditions¹⁵⁴. It is this knowledge they use to make decisions about what to *do* in

particular cases and situations. In other words they do not simply assess symptoms and physical signs objectively but interpret them by integrating the formal diagnostic criteria of a suspected disease learnt in their undergraduate education with the features of the individual patient's story and their own accumulated professional case specific experience and expertise.

Thus the knowledge that doctors use to reflect on their performance is a synthesis of theoretical and practical knowledge about clinical medicine in the community, the nature of general medical practice and the workings of the general practice consultation.

Frames of reference for evaluation

Four frames of reference for defining competence and success in consultations were evident in doctors' accounts, reflecting the perceived sites of general practitioners' knowledge and expertise. The origins of these frames of reference seem to be threefold. First the professional discourse about general practice and the general practice consultation outlined in chapter 2; second doctors' professional case specific experience; and third the prevailing views about what is expected of general practitioners from a managerial and health policy perspective. This final issue relates to the extent to which performance indicators designed to measure performance within the National Health Service as a whole have been assimilated into individual practitioners' views of their routine practice¹⁵⁵⁻¹⁵⁷.

The frames of reference for self-evaluations identified within doctors' accounts were

- clinical activities,
- communication and patient-centredness,
- relationship with patient, and

- therapeutic effect.

Together these frames of reference constituted a loose evaluative framework by which doctors assessed their behaviour and actions in the consultation. The very identification of this evaluative framework defines the consultation as a technical problem of practice for doctors and leads them to appraise, for example, their proficiency, efficiency and effectiveness in the consultation and arrive at positive or negative evaluations of their performance. In the following sections I will go on to explore doctors' application of this evaluative framework to their consultations and to describe the impact of this upon their satisfaction with the encounter.

Clinical activities

Diagnosis

Doctors revealed an expectation of being clinically competent and they routinely evaluated their performance in consultations in terms of the conventional deployment of medical knowledge and expertise. Technical deficiencies in diagnosis and treatment were almost universally not tolerated. Doctors frequently felt it incumbent upon them to provide the patient with an explanation for their symptoms even when such an explanation was not readily available or even necessarily sought. This doctor's succinct description of his emotive response to a consultation in which he had been unable to diagnose a "white blistery condition" in a child's mouth is illuminating.

"The short answer was I didn't know what was wrong with him, I didn't know how to treat it, the mother was perfectly aware of both of these and if it's any reassurance when I saw him again it had got better irrespective of my activities" (GP9)

Although he had failed to exercise medical expertise both in terms of diagnosis and treatment of the condition, this had resulted in no ill effect for the patient. Medical education onwards however privileges diagnosis as the domain of the doctor (vis a vis other health professionals). Failure to diagnose has consequences, if not for the patient, then for the doctor. He had been unable to assess his actions in this consultation as competent and this had left him feeling frustrated, and on an emotive level he had found the consultation highly dissatisfying.

Furthermore the resolution of symptoms in spite of his actions reveals an interesting dimension to doctors' evaluations of their own performance. The concept of having a therapeutic role is important and the ability to enact that role successfully is crucial to the sort positive self-evaluations that underlie doctors' most satisfying experiences. I will return to this theme later in this chapter.

The inability to access technical knowledge at an appropriate time is trying for doctors, and generally results in less than satisfying consultations irrespective of the other activities that occur within the interaction. For example in this consultation the doctor and patient have addressed more than one issue but the doctor focuses on being unable to name the patient's rash.

"I suppose that should have been equally satisfying (compared to a previously discussed consultation) but I'd have liked to have maybe a name for the rash or something like that...I almost had a name for the rash but I couldn't remember it. It was very similar to this rash that somebody had had earlier on in the year and the dermatologist had very cleverly called it 'itchy spots' in Latin which is what I said to her. It did look identical to that." (GP3)

This comparison of “illness scripts”^{154,158}, or stories of individual patients is a common process by which doctors arrive at diagnoses. Although she had effectively deployed practical professional knowledge in the consultation, the doctor is irritated at not being able demonstrate expertise. Previous professional experience is highlighted in many accounts as a means of developing practical knowledge that informs subsequent clinical action. Here for example the doctor’s actions are predicated on her past experience rather than on any impersonal knowledge of the probability of a given disease.

“I remember as a trainee having a young man who just felt ‘not right’ and I thought perhaps he’s depressed. I checked his urine and he was diabetic, and he ended up having hepatitis, followed by liver failure, followed by transplant. And he was really just as vague as that chap although I don’t think I would be able to reassure him without having some normal blood tests this time having had that experience.” (GP3)

Doctors’ past clinical experiences are however quite haphazard and the more striking and atypical experiences are remembered most keenly. These experiences not only influence subsequent experiences in terms of doctors’ actions but also in terms of their feelings about consultations. Despite seemingly appropriate diagnostic action within the consultation the doctor here still found this consultation amongst her least satisfying.

Conversely reaching a diagnosis was rarely valued of itself. In particular diagnosing acute conditions appropriately was a taken for granted part of general practice work. Making a correct diagnosis reduces the potential for doctors to make negative evaluations of their performance by removing the risk of missing a biomedical diagnosis, which is intolerable. This doctor is reflecting on a consultation in which he had made a new diagnosis of diabetes in a 60 year old

man. His pleasure at making the diagnosis of diabetes is outweighed by his relief at not missing it.

"I was quite pleased I had made the diagnosis because obviously it's the ultimate thing to miss, particularly when it is presented to you on a plate. The only reason he's still a patient, although he lives fairly well outside the area is that his aged mum who is a pleasant body lives in one of the sheltered flats and has been a patient for several years here. She's a nice lady so it would be, it's obviously embarrassing if you miss somebody who has a relatively major diagnosis because obviously one is going to continue to see the other person as it were." (GP9)

Management

a) Prescribing

Prescribing of medication is a very common act in general practice consultations and, in this study, prescriptions for medication were written in most consultations recorded. Interviewees saw prescribing as an important technical skill and they routinely assessed their prescribing practice in consultations. This assessment contributed to their overall evaluation of their performance in the consultation. Their accounts suggest that they felt it was possible for them to prescribe well or badly, and to identify when this had occurred. However they were also aware of the complex trade-offs that they made in relation to deciding whether to prescribe in the context of their interactions with individual patients.

It was clear that doctors regarded effectiveness as one criterion for good prescribing. In their accounts this criterion was implicitly defined against a biomedical model which sees disease as a physical disturbance that can be rectified by drugs. The assumptions of this model underlie prescribing guidelines

such as those issued by the National Institute for Clinical Excellence (NICE) and local regulatory bodies^{xv}. Circumstances in which the medication was, in their view, clearly biomedically indicated presented no problems for the doctor. Indeed it rarely merited comment and this assessment seemed to contribute little to their eventual evaluation of the consultation. This doctor reflects the typically matter of fact view of this aspect of their work in relation to a 40 year old man with an infected gash on his leg. This consultation was neither satisfying nor dissatisfying to the doctor.

“I slapped him on some antibiotics and told him to come back and see the nurse to get it dressed three days later. It wasn’t any more than it was.” (GP9)

Doctors were also aware of circumstances in which they considered it would have been inappropriate to prescribe. Commonly these situations included prescribing antibiotics for presumed viral infections, and requests for drugs of addiction.

“I thought ‘Well yes it’s a virus, and yes it’s going to take a few days’. And yet he wasn’t terribly happy with that. Now I know I used to dish out antibiotics...to make me feel better but the sort of campaign that’s been around has helped me a great deal.” (GP14)

Situations in which the anticipated biomedical effectiveness of medication was less clear cut were more problematic. Differentiating between bacterial and viral infection on clinical grounds is often difficult and the decision to prescribe or not was based on other considerations. Here this doctor is talking about his empirical

^{xv} In Lothian uplifts on prescribing budgets for practices have been determined according to compliance with “quality targets” which explicitly regard good prescribing as biomedically effective prescribing.

treatment of a severely disabled child who was febrile, but showing no focal signs of infection on examination:

“Yes it might have seemed bad doctoring, but you couldn’t interact with the child at all. He didn’t really know what was going on. Although sometimes you feel as if you should speak to them, because it’s insulting not to, but basically you have to just rely completely on what the mother said. And he gets really severe pneumonias, a chest infection basically and when he gets febrile it’s difficult not to treat him in that situation, he gets quite severely dehydrated” (GP10)

The doctor prescribed a broad spectrum antibiotic, which he regarded as questionable biomedically, but assessed his actions as responsible and judicious in the unique context of this individual patient. His evaluation of the potential costs to the patient of not prescribing helped him resolve any decisional conflict he was experiencing in relation to the effectiveness of the medication.

Doctors prescribed drugs with dubious biomedical effectiveness in a variety of situations. Compromises were commonly made in relation to preserving the doctor-patient relationship, a finding consistent with studies of prescribing decisions in primary care^{159;160}. This doctor is talking about a consultation in which she had prescribed the anti-viral drug aciclovir for a patient with a story of cropping of mouth ulcers which had been treated previously with aciclovir. The patient had requested a further course of the same treatment.

“I was just doing as I was told there. Obviously because it’s such an expensive drug that I (felt I) was being manipulated into prescribing. I didn’t see any alternative it didn’t seem sensible to challenge that.”

Interviewer: “Why didn’t it?”

“ I suppose she'd had by the sound of it a primary herpes which you're only going to get once. But you don't necessarily understand everything that's going on and I didn't really think it would be fair. I think she's under a lot of stress at the moment as well. She's got wee Caitlin, who has recurrent urinary tract infections and strange symptoms and Sandra's not really herself at the moment in general so I think I wanted to kind of get her on-side so that if she did feel like coming back with more then she would. I thought I had to give her the tablets to do that.” (GP3)

The doctor did not regard this as inappropriate prescribing despite the anticipated lack of effectiveness and high monetary cost associated with her actions, and the consultation was not one of her least satisfying. The reasons for this lie in the trade-off she has made between biomedical effectiveness and high cost and respect for the patient's choice, in order to preserve her relationship with the patient. The possibility for the doctor-patient relationship to be instrumental in improving the patient's general well being in the future is cited as a reason to prioritise its maintenance over biomedical considerations in this instance. In other accounts doctors revealed more prosaic and possibly less conscious motives in preserving their relationship with the patient. Indeed there was a tacit acceptance that this was a right and necessary thing to do. For example:

“I suppose the relationship was OK, it was very pleasant but I just felt I was perhaps giving a prescription more for that reason than for any medical reason” (GP5)

Doctors were always able to articulate a rationale for their prescribing decisions, even though the prescribing was not always biomedically or pharmacologically sound. This rationale saves them from making overtly negative self-evaluations in respect of their prescribing. Compromises of any sort however usually left doctors feeling uncomfortable about their actions and these consultations were rarely among the most satisfying for any doctor.

This data around prescribing is an example of the way the data in this study is inter-subjectively constructed. The interviewees were aware that I shared their experiences of clinical work and therefore took for granted that I understood the contests and tensions that surround the simple act of writing a prescription. We shared knowledge about the perceived downward pressures to prescribe effectively and efficiently, and we shared an understanding of the difficulties entailed in always following prescribing guidelines. Furthermore unsustainable claims about the biomedical basis for their actions were likely to threaten their presentation of themselves in the interview as a credible respondent and good doctor.

b) Health Promotion

Whilst prescribing was a habitual concern for doctors in their accounts other management strategies were less prominent. Despite the exhortations of the prescriptive literature about the general practice consultation health promotion activity did not emerge as a valued clinical task in doctors' accounts. Whilst observation of the consultations revealed the presence of some health promotional activity, this was limited in scope and doctors showed little propensity to evaluate it in their accounts. When doctors referred to health promotion activity it was in the context of managing ongoing problems, rather than as a pro-active act. In other words the activity was complementary to the rest of the interaction and had the potential to make a difference in the context of the patient's existing medical problems. For example this doctor is discussing secondary prevention of this patient's cerebrovascular disease.

"She's a very heavy smoker and I think you know that was part of my preventive strategy with her - to try and take her on because she had a TIA and she's been assessed at the neurovascular clinic and had Doppler's done." (GP2)

More prospective health promotion was never mentioned in doctors' accounts and engagement in health promotional activity does not seem to be necessary for doctors to positively evaluate their performance in consultations. It is beyond the scope of this study to explain why, but one hypothesis might be that doctors reject this type of "surveillance medicine" as too intrusive and outside their remit. Its absence from accounts is intriguing if only because it suggests that although much in their accounts is referential to the prescriptive literature about the structure and form of the consultation, doctors still make subconscious decisions about the practical relevance and value of the content.

c) Disease Management

Once again it was rare for the recorded consultations to be primarily concerned with chronic disease management. This is perhaps an artefact of both the organisation of service delivery at practice level and the design of the research. For the more common chronic diseases, in particular asthma and diabetes, many of the practices in which the doctors worked ran specific chronic disease management clinics, indeed some of the respondents had special responsibility for these clinics within their practices. Such clinics were however excluded from this study. Nevertheless from the observational data it was apparent that disease management was occurring in the consultations, but in their accounts doctors tended not to routinely examine the quality of this activity. In much the same way as they focused upon perceived difficulties in diagnosis and prescribing, they occasionally commented upon barriers to biomedically effective disease management but more often the actions and behaviours required of them in managing a disease were assumed.

Instead the disease management processes provided the context within which other, perhaps more challenging and potentially satisfying, aspects of the

consultation were discussed. For example in this doctor's account of a consultation with a female patient with hypertension, he perceives the challenge is not managing the patient's disease but managing her anxiety.

"This is quite a difficult consultation. Well in fact it would have been very difficult for anyone except me and I don't say that in a big headed way. It's just that I have dealt with this family and her husband has very bad Parkinson's. She's actually quite a fit lady although she's hypertensive and has become really really anxious in the last couple of years and I think a lot of her presentation is the effect of stress. She's really trying to say you know 'Can we talk about Mr MacKay..' type of thing.....She was sort of randomly found to be hypertensive by the nurse here. I also found she had a murmur. She's got a kind of aortic sclerotic murmur so I sent her to the cardiologist to just to get that quantified and it was they who suggested using the ACE inhibitor (to treat the hypertension) but then she's looked it up and ACE inhibitors shouldn't be used in aortic stenosis. But the gradients weren't so bad so I've this job of convincing her that because the cardiologist said it, it's OK." (GP7)

d) Referral

Referral rates have been suggested, and discarded, as a potential performance indicator for primary care and a way of monitoring the quality of care provided. Underlying the proposal was a belief that not all referrals to secondary care are "appropriate". Despite the subsequent rejection of the possibility of using such rates as a measure of the appropriateness of referral, the appropriateness of individual referral remains a tenet of best practice. A small minority of the consultations recorded in this study generated a referral to secondary care, and a small proportion of these were the focus of discussion in the interviews. However where referral had taken place general practitioners rarely commented explicitly on the perceived appropriateness of this action. However the fact of referral was often preceded by a description of the clinical scenario presented to me in such a way as to make referral seem inevitable. It is possible my status as a doctor meant the

respondents assumed I would understand the self-evident necessity of referral in these circumstances.

“It’s not just the heart block, she’s now got this dysrhythmia with it and she’s obviously symptomatic..

Int: Sounds breathless on the tape even..

So I’m hoping Dr Christie (cardiologist) will see her quickly.....”
(GP3)

And of this urgent referral:

“She came back this particular day saying she had woken up at two in the morning with central tight chest pain radiating down her arm and with palpitations. And she hadn’t done anything about it, she had put up with it thinking she wouldn’t disturb the doctor or it would go away soon but it had persisted throughout the morning into the afternoon when I saw her and I felt that it sounded cardiac. It was similar to how she had presented 3 or 4 years ago and had been admitted and monitored overnight and she had had a fast supraventricular tachycardia at the time. And she had (this time) an irregular fast pulse and her blood pressure was OK actually. So I felt it was the same thing happening again and so she ought to go in.”
(GP1)

Once again however doctors were aware of the context in which they were making decisions about referral. Again biomedical need was balanced with patient expectation and the need to attend to the state of the doctor–patient relationship. These contextual determinants were used to justify their actions and to configure their evaluations of these actions.

In summary doctors appear to become less comfortable with decisions around technical aspects of their work when these are suffused with psychosocial considerations rather than being biomedically pure. Yet paradoxically they find biomedically pure consultations “boring”. Therefore although doctors routinely evaluated their competence in consultations in terms of the deployment of medical

knowledge and expertise, they at the same time typically evaluated their performance in terms of practising medicine that values the interpersonal aspects of care. Consultations that merely required the straightforward application of biomedical knowledge and skills were rarely among their most satisfying.

Communication and patient-centredness

Patient-centredness has become established as the normative model of “good general practice” and the conventions of patient-centred consulting have become accepted orthodoxy. It is perhaps unsurprising therefore that the rhetoric of communication, and more specifically, the language of patient-centred communication featured strongly in doctors’ accounts of their experience of consultations. They often scrutinised the outcome of the communication between themselves and the patient and in so doing adjudicated on its quality.

Patient’s view

A central tenet of patient-centred consulting is the emphasis on the patient’s view and perspective. To quote Levenstein et al⁵⁰:

“The essence of the patient-centred method as it relates to the patient’s agenda is that the physician tries to enter the patient’s world to see the illness through the patient’s eyesThe central objective in every consultation is to allow the patient to express all the reasons for his attendance. The doctor’s aim is to understand each patient’s expectations, feelings and fears....”

Thus patient-centred consulting requires a thorough exploration of the patient’s ideas and concerns about their symptoms or illness and their expectations of the encounter with the doctor.

Unveiling these things is a key task for the doctor in the consultation. Nevertheless it was unusual for doctors to explicitly detail in their accounts the patient's ideas, concerns and expectations that they had uncovered. Rather they made a global assessment of how "completely" or well they felt they had achieved this.

They, now and again, commented that they felt they had reached a comprehensive understanding of the patient's view but did not do so routinely. It seems they expected to achieve this and this achievement was by and large assumed in their accounts. Understanding the patient's view became worthy of comment only when it had proved challenging to achieve.

More prominent in accounts were reports of difficulty accessing patients' views and, ultimately, perceived failure to do so. Such failure generally led doctors to negative self-evaluations and resulted in dissatisfying consultations. For example this doctor is talking about a dissatisfying consultation with a young man who was tired all the time.

"I think there was something more to it that he wasn't telling me. I was sort of fishing around desperatelyI don't think this chap had anything seriously wrong with him, I think he's a bit of the worrying type but very overworked. He was quite prepared to admit that. I'm just not convinced that I really helped him at all or really understood his problem" (GP3)

Patient's agenda

Difficulty accessing the patient's view ties in with the idea, prevalent in the literature about the general practice consultation⁴⁴, that the patient's agenda might be hidden. From their accounts it was clear that doctors expected patients to sometimes conceal their reason for attending. That is they anticipated that the

patient's agenda might be opaque. The communicative techniques by which this agenda can be revealed are commonly taught in undergraduate and postgraduate medical education. They require the doctor to be relatively passive and to facilitate the patient in revealing their view by, for example, actively listening to their story, using verbal and non-verbal encouragement to continue, using open questions, or statements as questions and echoing their words. Competence in these techniques was generally implied as a core professional skill and therefore other than in exceptional circumstances the doctors revealed an expectation of being able to achieve these ends through communicative action. Doctors rarely commented on their proficiency in these techniques in consultations in which their objectives were achieved. However in consultations in which doctors' aims were not achieved they rationalised this failure in their accounts by reflecting upon how the techniques, rather than themselves as exponents of them, had proved inadequate. Here the doctor perceives these techniques have failed to elucidate the patient's perspective and frustration ensues.

" I tried all the tricks that we teach registrars in communication skills, I let him talk and talk and talk....I was aware of not trying too hard to interrupt him and see if he'd run out of bullets.....despite my best efforts to ask open questions and let him talk and so on, we just got no further forward" (GP7)

and similarly,

" You know he feels quite certain he's got some underlying problem although he won't voice what he thinks he has....If he could say to me 'I think I've got' I could address his agenda better but he hasn't really expressed it" (GP4)

Shared understanding

The feature of patient-centred consulting foremost in doctors' accounts was achieving a shared understanding of the patient's problem. Doctors frequently

commented on whether they felt that they had reached a “shared understanding of the problem” with the patient in the consultation. In consultations in which the doctor perceived that a shared understanding of the patient’s problem had been achieved they evaluated this aspect of their performance positively. Such consultations were commonly regarded as satisfying.

“I think I was getting from her that she was beginning to agree with me that these were psychological symptoms and we could tackle them in a psychological way. I think she’s perhaps beginning to feel, yes, so we felt we had common ground on which we could move forward, even though she wasn’t necessarily feeling that much better, at least we’d achieved a shared idea of what the problem was.” (GP4)

Conversely those consultations in which they perceived such an understanding had not been achieved were generally less satisfying.

“I think the reverse of what was satisfying (in another consultation), because we didn’t reach a shared understanding of the problem and she went off and I hadn’t really solved her headaches and that left me feeling, well, that didn’t really go anywhere” (GP4)

In many situations where the doctor talked of achieving shared understanding with the patient this was, in effect, tantamount to the patient coming to appreciate the doctor’s view of their problem. Furthermore doctors’ accounts suggest that they regard this view as representing the reality of the situation. Educating the patient into accepting the reality of their view was therefore considered a success.

Doctors talked about failure to achieve a shared understanding in situations where they had failed to convince the patient of the primacy of their own view (compared to the patient’s view). This difficulty often hinged around the doctors’ perception that the patient was inappropriately adhering to a biomedical perspective on their problems.

For example:

“He can’t reach a shared understanding, he’s sure he’s got something physical. Nothing physical has appeared, there’s nothing to find examining him. I think these are probably anxiety-related symptoms. He’s been off work for ages so he’s probably going to lose his job so you feel it’s a great shame you can’t intervene in that situation.” (GP13)

Here the doctor is using the rhetoric of patient-centredness to explain the experience of a dissatisfying consultation. The account suggests a failure to reconcile the patient’s agenda with her own because of the intransigence of the patient’s view. However it might equally be the case that she has failed to enter the patient’s world and see his illness through his eyes. Patient-centred methods are underpinned by an appropriate set of professional values¹⁶¹ which include interest in and receptiveness to the patient’s agenda, and belief in the patient as an expert in his own illness. In their accounts doctors sometimes talked about consultations in which it was clear they did not believe the patient was an expert of any kind

These accounts suggest that doctors view the consultation as the site of a “reality” and that there is a sole truth of any presentation. This view arises from the assumption implicit in the patient-centred method that it is possible for a diligent and proficient practitioner to discern the patient’s agenda even if it is initially hidden. Failure to reveal this agenda is then viewed as a technical failure of the doctor’s actions and behaviour within the consultation and results in a negative evaluation of their performance, and a consequently dissatisfying experience.

The concept of reaching a shared understanding of a problem hints at the possibility of an intrinsically inter-subjective construction of the patient’s problem. That is, although the doctor and patient cannot have the *same* understanding of the problem because they approach it each from their own unique perspectives, they can nevertheless share something of the other’s experience of the problem.

For example this doctor is detailing the process by which he let himself into the patient's experience of her problem or reached a mutual understanding of her problem.

"I think it was probably something to do with again connecting well with the patient, imparting some...explaining something well. Finding again, finding out a bit about her background and the impact it had on her studies and what have you, and appreciating the difficulties that that was causing her, and communicating that appreciation to her." (GP6)

It is not likely that he ends up with the same understanding of the problem as the patient not least because his own experiences have led him to define the parameters by which he judges her experience. However this sharing of the experience seems to allow the doctor to respond to the patient as an experiencing individual rather than as the object of organic or psychogenic pathology.

In consequence the patient is likely to feel understood by the doctor and possibly empathised with. It is clear that the concept of shared understanding is associated with the idea of empathy. However it is not synonymous. Empathising with a patient involves the doctor identifying mutually with them so that the doctor might fully comprehend them. Hence empathy relates to an understanding of the person and not just their problem. It is clearly easier for doctors to empathise with some people than others. Those patients with whom they share more characteristics are likely to be empathised with more fully.

The ease with which doctors perceived empathy was achieved in consultations was seen as adding value to the consultations for them and perhaps for the patient. Here this doctor is integrating her own life experiences into an evaluation of a satisfying consultation.

"There's nothing better than seeing a couple with infertility and then a few years later looking after their child and the pregnancy and everything. So I find that very rewarding when it works. I think I've probably got a little insight into the—not that we've been infertility patients, but into the—waiting for a pregnancy, the anticipation, the disappointment and that kind of thing. So I think I can empathise quite well with people in that situation, so I'm quite pleased when they come in with that sort of problem..." (GP8)

This doctor reports how he perceived his own experience of ill health had helped create a rapport with this patient, and the consultation was among his most satisfying.

"I diagnosed something with her that was odd and it was just lucky – lucky because I've had this condition myself and it was very odd and I felt that created some rapport between us." (GP6)

Shared decision making

In contrast to the ubiquitous references to shared understanding, doctors' accounts of their consultations rarely particularised the concept of negotiating management with patients despite this being a similarly cardinal feature of the patient-centred method. Occasionally they did acknowledge, in general terms, the desirability of shared decisions, for example:

"It's nice to make decisions with people rather than by them or by you I suppose. A joint decision is probably better." (GP10)

Nevertheless their accounts tended to suggest that shared decision making was rare and more commonly doctors shared the reasoning behind their decisions with the patient to convince them of their logic and to encourage them to agree. This doctor is talking about the process by which he persuades his patient to take more anti-anginal medication.

"I tend to let things drift a bit and in that drifting period sound out the patient as to what they would feel about changes and then if you do decide to make the change then you know that the patient is with you. But I'm quite happy to make the decision. I don't prevaricate around it." (GP7)

However with regard to clinical decision making doctors were more likely to comment when they felt they had been deprived of their capacity to make decisions in specific consultations. Their accounts detailed instances where they felt they had been rendered powerless and dissatisfied. Chapter 5 focuses on one discursive strategy used by doctors to account for this impotence: that of negatively evaluating the patient.

Patient-centredness as 'inappropriate'

Doctors were able to identify situations in which they had practised doctor-centred rather than patient-centred communication. They generally indicated that they did not, as a rule, regard this as ideal professional behaviour but given the way they had evaluated the patient this was seen to be appropriate and practical in specific instances. Thus a consultation in which the doctor had contravened the parameters of ideal professional behaviour was still able to produce a positive emotive response.

This doctor is talking about a consultation he had found satisfying. The consultation had been doctor-centred with the focus being on his need to evaluate the patient's medical problem and decide upon the necessary action.

"So if I can remember rightly she'd had an endoscopy or was waiting for results of a H.pylori test and I was trying to unravel whether or not I needed to investigate it anymore. And I think within the complicated notes in front of me I decided that it was just heartburn she was talking about and just needed lansoprazole and I didn't need to investigate it anymore. Whether or not she understood that I wasn't quite sure?

Int: How did you perceive your role in that consultation?

"I suppose looking at the parent-child relationship, it would be that....That's not always the right thing to be doing. You should be doing more of a sort of joint situation but there are occasions when everybody needs to tell somebody what to do sometimes during the day. Maybe that was my one for doing it that day. I think she is the sort of person that needs that done to her." (GP10)

Thus the doctor is able to reflect positively on his performance because of a wider evaluation which sets his specific actions in the consultation in a particular context. He makes sense of the patient and his own actions through an interpretation of this context.

Throughout the accounts of consultations it was common for doctors to comment on the communication between the patient and themselves when they were unhappy with the communication. Poor communication was rarely tolerated and tended to be associated with doctors making negative evaluations of their performance in consultations. Occasions where communication was perceived to have been acceptable were less commonly noted suggesting that this is another taken for granted aspect of competence in the consultation. This is analogous to doctors' tendency to concentrate on difficulties in diagnosis and management rather than on everyday accomplishments in their clinical work. Again the way in which doctors circumscribed their accounts of unsatisfactory communication was with reference to the characteristics of patient-centred consulting. Thus the rhetoric of patient-centredness can be seen as partly configuring their concept of the competent general practitioner.

Relationship with patient

Doctors' evaluations of the patient-centredness of their consultations involve them applying a technical model of communication. This model clearly has its roots in the professional discourse about general practice. The prominence of communication in the doctors' accounts hints at the importance of communication as a site of specialist expertise for general practitioners. This perception is engendered by the emphasis placed on communication and consultation skills in postgraduate general practice training exemplified by summative video assessment of registrars. The professional focus is on achieving specific goals through specific communicative action. In contrast although patients regard good communication as a central concept in adjudicating on the quality of doctors¹⁶², it is seen as a proxy for a doctor's underlying interpersonal characteristics and a pre-requisite for a good doctor-patient relationship.

Other authors have noted this distinction between the specific micro level analysis of communication by professionals and the more global evaluation by patients¹⁶³. They have detected a trend in the way doctors' reflect upon their encounters with patients. They suggest that consideration of the quality of communication in the consultation has superseded assessment of the quality of the relationship. They contend that new patterns of working have prioritised different behaviours and practices and marginalised the personal relationship between doctor and patient.

However this distinction between the analyses of doctors and patients is perhaps not as clear cut as previously suggested. My data suggests that despite contextual changes, such as larger partnerships and extended multidisciplinary team working, doctors continue to value the intimacy of a close doctor-patient relationship. Interviewees subscribed to the concept that the doctor-patient relationship is instrumental in practising medicine and that in order to practice

“good medicine” the relationship needs to be established and maintained. As I will go on to discuss in chapters 5 and 6 (evaluating the patient, and knowing the patient respectively) the nature of the relationship is important in helping the doctor reach both a diagnosis and decisions about treatment. Furthermore doctors perceive this relationship to be much more than a simple alliance configured by their communication skills. It is seen as a dynamic entity: something to nurture and protect, and evaluations of its state are integral to the evaluations doctors make of their performance. It is, in this context, more than knowing and evaluating the patient, it is about situating *themselves* in the relationship. They have a position in the relationship and they evaluate their performance in consultations in relation to perceptions of that position. Following consultations which doctors felt had contributed positively to their relationship with a patient, their performance was more likely to be appraised well. Potential deterioration in a relationship as a consequence of the events of a consultation was lamented.

Therapeutic effect

I have described the way in which doctors examined the consultations in which they had taken part and evaluated their behaviour and actions in relation to an intrinsic framework. In this evaluation they have acted as detached observers of the events in which they have taken part. Beyond this my data suggests that doctors also evaluate how successful they have been in specific consultations. This is a more subjective evaluation. Practising “good medicine”, being a “competent doctor” was the foundation for being successful but the touchstone of success was perceiving therapeutic effect from the consultation. Being successful was a decisive aspect of doctors’ accounts of their most satisfying experiences.

In describing their experience of individual consultations, interviewees habitually talked about their therapeutic utility. Satisfying consultations were almost invariably ones in which the doctor perceived that they had achieved something, “moved things forward”(GP4), or “made a difference”(GP11). However it was also clear that in their accounts doctors privileged certain kinds of success. The “routine disposal” of problems in consultations, generally minor physical morbidity, tended to be valued less in accounts than attempts at complex problem solving. Curing a biomedical problem was seen as bread and butter “generic” general practice work, affording little opportunity for enhanced professional satisfaction. Doctors typically appreciated practising medicine that values the interpersonal relationship between doctor and patient. Greatest satisfaction seemed to be derived from consultations in which the doctor perceived they personally had contributed to the success. The basis of this criterion would seem to lie in the professional discourse about the doctor-patient relationship that views it as intrinsically therapeutic. This view has as its origin the work of Michael Balint¹⁸ that was so influential in the professionalisation of general practice in the 1950’s and 1960’s.

Conditions for therapeutic utility

Within the data it was clear that perceiving therapeutic effect was contingent upon the existence of certain conditions within the consultation. These conditions centred on issues of control and power. In conventional sociological critiques of medical practice, power and control are ascribed to doctors, and patients are seen to have control exerted over them and power imposed upon them. The doctor’s power is considered to reside within the institutional power of the medical

profession^{xvi}. Analysis of this data suggests very strongly that the dynamics of the general practice consultation are not as straightforward as this. In fact doctors' accounts suggest that power and control is commonly contested in consultations. Furthermore this contest is not exclusively about the patient trying to wrest control from the doctor but also about the doctor trying to divest himself of power and disabuse the patients of the notion that the doctor is all powerful. Resolution of these contests and tensions emerged as a condition for therapeutic utility.

From the doctors' perspectives, the sites of control in the consultation are the formulation of the patient's problem, the structure and form of the consultation, and the predictability of its outcome. From doctors' accounts it seems that contest in consultations can occur at none, some or all of these sites. I will consider each of these sites in turn.

a) Formulation of patient's problem

Taking first the formulation of the patient's problem. Doctors were primarily concerned with feeling that they had an overall picture of the patient and their clinical problem. It was clear that this "overall picture" was much more than a thorough understanding of the patient's clinical condition or indeed a shared understanding of their problem. It involved extension of their remit into surveillance of the patient's life circumstances. For example:

"I think fundamentally I was reassured, well I felt that I had an overall picture of this guy. I felt I had a clear idea of all aspects of his health and of his life." (GP1)

^{xvi} Alternative conceptualisations of power have been proposed, notably by followers of Foucault.

Thus the problem of diagnosis seems to re-emerge in the context of complex problems. When the doctor recognises the interplay between the physical, psychological and social aspects of the patient's illness, a whole person diagnosis is possible. This broadening of the "clinical gaze" in the consultation opens up possibilities for failure of diagnosis and incomplete diagnosis again. Interviewees were frequently aware of this and when evaluating their performance in evidently biomedical consultations reflected on the likelihood that the physical conditions presented by the patients were somatic camouflage for more complex psychosocial need. To have failed to detect this more pressing need was seen as a culpable act.

"I suppose that was satisfying because it was fairly cut and dried. I do know her quite well and I didn't think there was anything that, there weren't really hidden agendas. She did have a very sore ear, and it looked very sore and it had responded to antibiotics in the past, and she felt quite convinced that if I gave her an antibiotic she would feel better, but of itself it was uncomplicated so I was satisfied that in the sense that I didn't feel there were things that I hadn't addressed." (GP3)

Clearly in such satisfying consultations the doctors had little doubt that they had correctly and completely assessed the patient's problem. They perceived no contest around their formulation of the patient's problem. It was most commonly implicit in their accounts that the patient was in agreement with this formulation. In consultations they perceived as less satisfying evidence of contest about the nature of the patient's problem emerged. Typically doctors expressed frustration at not being able to "get to the bottom" of a patient's problem or not "having a handle" on it. As a rule these frustrations arose in situations where a biomedical formulation of the patient's problem was not possible and a psychosocial aetiology was envisaged by the doctor. Characteristically however the doctor was unable to decipher the psychosocial influences on the patient's problem and hence the formulation of the patient's problem remained contested in their mind. This

interviewee is discussing an unsatisfying consultation with a 22 year old man who was tired all the time.

“And I think there was something more to it that he wasn’t telling me. I was sort of fishing around desperately to (find it)I don’t think this chap had anything seriously wrong with him, I think he was a bit of a worrying type...I’m just not convinced that I really understood his problem.” (GP3)

Nevertheless, the perception of having a clear understanding of the patient and their problem was usually not sufficient in itself for doctors to perceive therapeutic utility. Rather, in most circumstances, as a condition of therapeutic utility the patient and the doctor are obliged to reach a mutual understanding of the provenance of the patient’s illness. This process often involves contest and tussle between the perspectives of the patient and the doctor. The doctors’ accounts are peppered with references to this contest and its resolution or otherwise. For example this interviewee is talking about a consultation with the mother of an eight year old girl who had a chest complaint.

“That girl’s mother tends to be very negative and, not complaining, but you perceive that what you are attempting to do with her children isn’t quite good enough. And I felt, having seen her over the previous consultation, I mean I’d seen her frequently in the past but I felt we might be heading for trouble, that we weren’t going to get anywhere. Then to find that what I had suggested and stuck with had, if you like, won out and improved her clinically even to the extent of her mother being pleased about it, that I suppose gave me an inner satisfaction, not just in a diagnostic sense but in the sense that you’d got someone over to your way of thinking, perhaps convinced them that what you had been trying to say was in fact reasonably OK”. (GP7)

The struggle for control here involves the doctor convincing the patient’s mother of the validity of his view of the physical cause of her child’s symptoms. Similarly this doctor is recounting how her patient had come to acknowledge that her physical symptoms had a psychological basis. Again the doctor is satisfied that the patient

has accepted her perspective on the aetiology of her problems. That is the doctor has had the upper hand in the formulation of the patient's problem.

"I was getting from her that she was beginning to agree with me that these were psychological symptoms and we should tackle them in a psychological way. I think she's perhaps beginning to feel, yes ...so we felt we had common ground on which we could move forward, even though she wasn't necessarily feeling that much better, at least we'd reached a shared idea of what the problem was." (GP4)

Sometimes it is not possible to agree the diagnosis with the patient or at least for there to be agreement about the underlying reason for a patient's presentation. In these cases doctors rely on negotiating the reality of the patient's experience¹⁰⁸. In other words they employ strategies that lead the patient to believe their suffering is understood and appreciated.

"It's like 'What on earth's this?' You know it's like 'What's she going on about now' and I wasn't very clear about what it was even from the history.....Anyway I was examining her and I'm pressing on her pubic symphysis and that seemed to be very painful and thinking 'What on earth can this be?'I just said it 'People have operations for this you know'I kind of said it partly to suggest to her 'Oh yes I think there is something here, lets get an expert to look at it'." (GP14)

In some instances the doctor does not engage in potential contest and instead accepts the patient's view. This tends to occur in situations where the doctor perceives the outcome of the consultation is predictable whatever the formulation of the patient's problem.

"I think I was satisfied that she wasn't depressed this time because she would have told me. She's quite happy to come out with that kind of thing So I felt that I didn't necessarily need to dig for anything...If she says she wants her pills she probably just wanted her pills. And she was happy to explain away the spots then I was happy with the explanation." (GP3)

Whilst such consultations were rarely among doctors' most satisfying, neither were they generally dissatisfying. Thus the patient's illness can be viewed as having no objective reality that the doctor needs to discern but rather as being constituted by patient and doctor into a form that both can accept as true. When this is the case the doctor feels able to exercise therapeutic effect, but it is likely that the power to do so is constituted in the interaction between the doctor and the patient and not exerted unilaterally by the doctor. For example this doctor is talking about a consultation in which the psychosocial root of the patient's problems was acknowledged, recognised and understood by both of them leading to a positive outcome of the consultation.

"Well it can be a difficult job sometimes. Making the connection between a real physical symptom like a cramp, gut ache and stress can be quite hard. I mean people find that you know there are a lot of cultural things like if you're saying it's stress then they are imagining it and you've got to overcome that, and help them understand how the way they feel can produce quite real measurable physical symptoms.Then he started asking all sorts of difficult questions like 'how's that connected with me having to get up and pee all the time?' and I was able to draw those all together for him." (GP16)

In contrast, unresolved contest about the root of the patient's problem and its formulation robs the doctor of a sense of control over the consultation and the ability to be therapeutic. This doctor is describing a failure to negotiate a mutually acceptable formulation of the patient's skin problem which might form the basis of therapeutic work. The consultation was among her least satisfying.

“My problem is that looking at his skin it certainly wouldn’t warrant roaccutane, I mean it wasn’t that bad and it’s more obviously I think more of a psychological (thing).... I kept saying to him, making suggestions and he’d go ‘Well, I tried that and it’s no good’ and you know so I suppose part of the dissatisfaction was that clearly it would not be in his interests to take roaccutane specially not with his mood problems and his skin didn’t warrant it and somehow we didn’t manage to communicate that, I didn’t think. I didn’t find a way to communicate that satisfactorily,I kept saying my thing and he kept saying ‘but I’m driven mad by this, I hate it. You might think it’s trivial but I think it’s terrible’ . And every time I tried to get into the psychological thing he just blocked it you know.” (GP5)

Here the consultation is the site of conflict between two ways of constructing meaning about the subject matter of the consultation (the patient’s skin). The doctor interprets the consultation within a biopsychosocial framework but this is resisted by the patient who sees only relevance in the biological.

b) Structure and form of consultation: time and order

In terms of creating a viable and satisfying work role Horobin¹⁶⁴ found that general practitioners conceptualised time as a scarce resource. This finding is upheld by the present analysis but the way general practitioners talked about the limitations this imposed upon them was different. The effect of perceived shortage of time was most commonly not “risk in routine diagnosis” as Horobin found but difficulty in making the sort of extended diagnosis required to practice holistically and to act therapeutically. Interviewees were aware of differentially allocating time in surgeries according to the potential gain they perceived from making a whole person diagnosis. In other words if they perceived formulating the patient’s problem holistically was likely lead in an individual situation to a more positive outcome they dedicated more time to the consultation. When they perceived that the decision to use time in this way had been vindicated they evaluated the consultation and their performance in it positively. For example this doctor explains her satisfaction with a consultation with a nurse complaining of generalised joint pains.

“Probably the fact I took twenty minutes over it. I think when you get something like that you’ve got no option if you’re going to do it properly but to take the time and I know that leads to other problems in the surgery but with something like that you have to take the time and I think that’s rewarded because I’m sure she’s not going to come back, I’m sure she’s satisfied with the fact that her aches and pains will get less and she won’t come back. (GP19)

Here the effort invested by the doctor has been rewarded by a perceived positive outcome in the consultation. The risk associated with investing time in consultations was evident but, in this instance, worth taking. Elsewhere the tension between the doctor’s temporal agenda and the unpredictable consequences of exploring a patient’s psychosocial state has been highlighted¹⁶⁵. The present analysis suggests that tension exists at a level beyond this, that is between the decision to invest time in the patient’s inner feelings and the consequences of this being unsuccessful. In situations where the risk was perceived as not worthwhile, that is produced little in the way of a desirable outcome for the doctor, the interviewees reflected on the consultation with discontent. This doctor describes the tension between a desire to practise holistically and the recognition that this requires time she perceives she might not have, and her subsequent frustration at investing precious time with no discernible benefit.

"She came in with a couple of problems and one of them was she'd some breast pain and she also had a discharge and she'd seen people before and they were kind of non-specific, breast exam was normaland then we went ahead and did a pelvic exam, sent a swab off ..and I can't remember whether I asked about when she had her last smear or asked if she had any pain on intercourse or anything and she made one of these off the cuff comments "we don't really do that anymore" and I was running late and there was kind of this dilemma whether to ask about it, so I duly did ask about it "what do you mean by that? Is that by choice" She goes "oh well I don't really feel interested in it" I said "is that a problem?" She goes "not for me but for my husband" So I asked her if things were getting her down and she was a bit depressed and she kind of said yes but she wasn't really wanting to talk about it.She'd got kids and she made a comment at the beginning that she hardly ever came because she was usually only worrying about her children and I suppose to an extent although I spoke to her about it a bit I kind of thought I didn't really push it as much as I potentially could and I think I was aware of the fact that at that point I was running extremely late and because she wasn't taking me up on any of the overtures I was making, I felt I hadn't ignored itWell, you kind of think if you had absolutely unlimited time whether if you'd pressed her a bit more whether she would eventually have said "yes, I really am (depressed) I'm not sleeping and you might have actually convinced her to do something" (GP17)

Thus time becomes a condition of therapeutic utility. Perceived lack of time or inefficient use of time is one of the reasons a "good doctor" feels unsuccessful and finds consultations dissatisfying. Best use can be made of time when there is order in a consultation. Order in the consultation means that the consultation follows a roughly predictable sequence with which the doctor is very familiar, that the doctor and the patient understand the rules of this interaction, and that the patient's expectation is compatible with the doctor's. When these conditions were met, interviewees talked about "feeling in control".

Doctors would not generally be prescriptive about the content of consultations but would expect to be able to control their structure and form, that is the way in which the patient provides his or her account within the consultation. This structure facilitates the doctor in doing his work, the work of a good doctor. When the form of the consultation is facilitative of the doctor's work, this control is taken for granted and interviewees made no comment on it. Conversely when the form of

the consultation is not conducive to the doctor accomplishing his work, it merits attention. Here the doctor is talking about a consultation which he had found unsatisfying and is describing the conduct within it of the patient and her family.

“ Both she and her family have been complaining of aches and pains for quite a long time. She’s complained of lots of aches and pains over the years. It’s always difficult to get a terribly good history from her. Quite often consultations with her are interrupted by her husband wanting to have a consultation about himself at the same time, or her son wanting to have a consultation at the same time. You never really get through to her, she’s at least taking her blood pressure pills, but it’s all sort of a mishmash and unsatisfactory.”
(GP9)

Hence the doctor has lost control over the form of the consultation. But not only this, the patient (and family) are not abiding by those unwritten rules for the consultation that say one consultation one patient. So even when the form of the consultation is predictable, order in the consultation relies on both doctor and patient ‘playing by the same rules’. When this is the case, it warrants no comment in the doctor’s account of the consultation but when it is not the consultation becomes problematic. These unspoken rules pertain to understanding of the reasonable possibilities of a ten-minute consultation and the conventions that surround it. These include conversational turn taking by doctor and patient, concentration on one issue at a time, and regard for the doctor’s temporal agenda.

This patient was perceived to flagrantly ignore these realities and the doctor found this consultation very dissatisfying.

"She comes a lot and when she comes she's a bit of a heartsink because she's a half hour appointment in a ten minute slot and she always is....She's someone who won't, she doesn't just present the symptoms and allow you to get on and make your explanation she's someone who's always again looking for a wider ranging discussion about it all.....When she's in everyone else is irrelevant. There's no awareness she's in for a limited time." (GP12)

Order in the consultation also involves patient and doctor having common expectations of what is possible in the consultation. This is about more than the conventions of the consultation and includes having collective aspirations for the consultation. Typically doctors feel in control if they have at their disposal the therapeutic armoury to meet the patient's hopes. In the circumstances of unexplained physical symptoms and insoluble clinical problems, doctors perceive powerlessness. In such instances doctors perceive patients to be seeking diagnoses and treatments they cannot offer and such consultations were routinely dissatisfying for doctors.

"It's got to do with people wanting me to do something when there isn't anything to be done and not being able to agree about that. They are looking for something that could be done and I have not really wanted to do it, so I've sort of let them down in some sort of way whereas I'm feeling there actually wasn't anything I could do but I just haven't been able to help them to see that it's something they perhaps need to live with or find different ways of dealing with," (GP16).

c) Predictability of outcome

Control can also be lost in the consultation when the outcome is unpredictable. Occasions on which this might occur not only include difficulties in formulating the patient's problem or making a diagnosis but also when the patient contests the doctor's therapeutic will. That is the doctor perceives they have no influence over the patient's actions. This highlights a further tension in the consultation. For whilst doctors can feel a sense of control over the way the patient's problem is

constituted, at the same time they can be rendered powerless by the patient's refusal of responsibility. When this is the case the outcome of the consultation is unpredictable and the doctor is often dissatisfied with the consultation

"Just because he's somebody that the more I try and help him the more problems he comes up with and he is one of those people who doesn't listen to what you say. You know he comes and he says he's got this problem and you say why don't you do this, and then he comes back a month later and he's still got the same problem and he hasn't done that so you repeat yourself....He sort of disempowers me in a way I suppose. But he still keeps coming back to see me" (GP8)

Conditions for therapeutic utility met

Once the conditions for therapeutic utility have been met in terms of a "whole person" diagnosis and order in the structure and form of the consultation, the opportunity arises for the doctor to exercise his own personality in the consultation. This deployment of the doctor's personal attributes-as opposed to his formal medical knowledge and technical skills-seems to be crucial to the doctor's perception of his therapeutic utility and to his satisfaction.

"I felt there was definitely some possibilities of getting somewhere, I felt that I was the right sort of person to be seeing this woman and I was more likely to be able to get somewhere with her than certainly any of my colleagues...partly well (because of) my experience both in medicine and previously as a social worker I feel very comfortable with the messy sort of complicated psychosocial problems, I've got a large amount of experience of them and a lot of different angles that I can sort of employ.." (GP15)

The outcome is seen in heterogeneous terms too, not as the treatment or cure of a disease but as restorative of the person therapeutically. For example, this doctor is

reflecting on his satisfying experience in a consultation with an elderly gentleman with coronary heart disease and constipation.

“ I knew that having been to see me would have had a good effect on him and that he would go home thinking “Right I feel happier” I felt there was something else I had contributed to him, the contact had been worthwhile” (GP1)

Effective deployment of the doctor’s own personality was regarded by respondents as the bit of their work that demarcates the “art” and uniqueness of their discipline. Interviewees recognised that this was difficult to teach and far from straightforward to do but nevertheless they considered it important to develop. It was therefore one way in which interviewees commonly exemplified their expertise.

“This is where you start saying the “art of medicine” isn’t it? But I suppose it’s true to a certain extent. Because these, there are things you can teach and learn to a limited degree, but things certainly you refine, you get better at and some days you are good at doing them and some days you’re just crap at doing them. On that day with that fellow, I felt like I was doing alright with it and I suppose that’s why I thought it was fine.” (GP11)

The unsuccessful doctor

As expertise was in to a large extent about the doctors feeling they could bring their own persona into the consultation, it was in consequence considered an individual attribute. This implicit acceptance of the concept of the “doctor as drug” which is one of Balint’s legacies to general practice throws into sharp relief occasions when the doctor can demonstrate no or little therapeutic efficacy. Opening up the patient’s social life to medical scrutiny not only expands the range of understanding of patients’ ill health but also paradoxically enhances the potential for the doctor to be rendered powerless. For the concomitant expansion in

the array of problems that are now considered amenable to the ministrations of doctors for example debt, housing problems, relationship difficulties has not been accompanied by commensurate development of the doctors' therapeutic repertoire.

The expectation that medicine can intervene in all manner of suffering thus sets up a contest for doctors between their desire to embrace a holistic approach to their practice and the practical limitations of their everyday work. When these are highly discrepant the doctor's emotive response to the consultation is usually negative or at best ambivalent.

"Well I think I find it (practising holistically) rewarding if I've got time to do it properly. I mean if that patient is lucky enough to come near the beginning of a surgery when you're not running too late so that you feel you've got the time then yes I do find it rewarding to sort of listen and get them to tell me what's going on.....but there are times when you just don't want to know and you can almost feel yourself putting up the "don't tell me your problems face". I mean like this afternoon when I had 17 patients, I mean if somebody had started trying to tell me a story like that this afternoon I wouldn't have let them finish probably and then I would have given them a really bad service.And then that makes you feel bad. So they're not always rewarding."(GP8)

Conclusion

It seems there is a clear relationship between the way doctors appraise their performance in consultations and the prescriptive literature on the theory of ideal general practice. In terms of presenting themselves as competent practitioners doctors' accounts are clearly referential to this literature which embodies the prevailing ideology of the profession. Indeed it appears they have limited alternative ways of accounting for their actions in the consultation. The limited and routine practices that constitute the bulk of what happens in consultations are only tacitly acknowledged in much of the literature, and they form a commensurately small

part of doctors' accounts. In contrast the colossal literature around the biopsychosocial model and the patient-centredness of general medical practice is reflected in the extent to which doctors engage, in their accounts, with psychological and social discourse. Paradoxically their accounts hint at discontinuities between much of the theory of practice and doctors' everyday work. Although doctors feel constrained to account for their experiences through reference to a biopsychosocial model of practice, and a patient-centred mode of operation, the practical limits of the interventions open to them means that they often have limited success in helping the patient resolve problems outside the biomedical domain. Therefore the model of ideal practice subscribed to by practitioners and the practical exigencies of their everyday practice often remain discrepant. This is a source of dissatisfaction in consultations. However when doctors are able to productively engage with the patient to facilitate this kind of success, the intrinsic value of the relationship between doctor and patient is perceived to lie at the heart of this success. This not only provides opportunities for maximal satisfaction in consultations but also this view of the relationship liberates general practice in terms of defining the nature of expertise in the discipline. The expertise of general practitioners therefore resides in the successful cultivation of relationships and their application to patients' problems.

Summary

In this chapter I have described how doctors evaluate the competence and success of their performance in consultations. I have shown how positive evaluations are important in producing satisfying experiences in consultations. I have suggested that doctors appear to draw on an implicit evaluative framework in examining their consultations. This framework includes consideration of the clinical activities within in the consultation; the communication occurring in the consultation and

its patient-centredness; their relationship with the patient; and the therapeutic effect of the consultation. This evaluative framework arises from doctors' awareness of prevailing political ideas about what constitutes quality primary care, from their knowledge of the professional discourse about general practice and the general practice consultation and what is consequently regarded as ideal professional behaviour, and from their own professional experience.

Doctors judge their competence in individual consultations against minimum standards for technical clinical and communicative competence. The results of much of this evaluation remain unarticulated in their accounts because the presence of technical competence in consultations is taken for granted. The bottom line evaluation that doctors make is 'are my actions those of a competent doctor?' Doctors find their technical clinical and communicative actions more problematic when they are influenced by contextual considerations. Doctors struggle to reconcile biomedical best practice with the imperatives of interactions with individual patients leading to unease. The root of this discomfort might lie in their view of the consultation as representing a sole reality that gives the consultation an objectivity their experience cannot always sustain.

More subjective or relative evaluations are made in terms of the success of each consultation. This is based on the perceived therapeutic effect of the consultation. Here productive involvement with the patient rather than with their symptoms or presentation is the cornerstone of success. This not only involves engagement with the patient's subjectivity but reaching a shared understanding with the patient of the reality of the consultation. Positive evaluations of their therapeutic utility in consultations are central to doctors' most satisfying experiences in consultations.

In the next chapter I will go on to discuss how the way in which doctors' morally evaluate patients influences their ability to be therapeutically useful, and consequently impacts upon their satisfaction with consultations.

CHAPTER 5: FINDINGS – THE DOCTOR’S MORAL EVALUATION OF THE PATIENT

Introduction

In the previous chapter (evaluation of self) I have suggested that the way in which doctors experienced satisfaction in and with consultations was related to their perception of having demonstrated competence and achieved success. Perceiving success was linked to a view that the consultation was therapeutically useful. I have alluded to how aspects of the patients’ behaviour facilitated or militated against the doctor feeling competent and influenced the presence or absence of the necessary conditions for therapeutic utility. In this chapter I will go on to discuss the evaluations doctors made of patients and how they used these to account for their capacity to demonstrate competence and act therapeutically, and for their emotive responses to consultations.

In the present study doctors’ evaluations of patients emerged as a strong theme in the analysis. In the majority of consultations discussed, the doctors’ accounts included some reference to the feelings the patient had evoked in them, and to the perceived character and characteristics of the patient. It was clear that patients frequently invoked quite strong feelings in doctors and that these feelings were important in the way they experienced consultations. It was equally clear that there was a link between these feelings and the moral evaluation doctors made of their patients, and indeed the moral evaluation they made of themselves as a “good doctor”. Doctors’ accounts suggested they evaluated their patients in terms of both their personhood and their patienthood.

Perspectives on moral evaluations of patients

That doctors morally evaluate their patients is not a novel finding. Indeed the issue of moral evaluation of patients by medical and nursing practitioners has stimulated a good deal of research both from the sociological tradition and from the clinical perspective¹⁶⁶. Much of it relates to health professionals other than doctors, in particular to nurses, and to settings other than general practice, for example accident and emergency departments. It is therefore beyond the scope of this thesis to review most of this literature other than in the most general terms. However broadly speaking the research reveals two different perspectives on evaluations of patients. The first perspective, a clinical one, sees these evaluations as problematic for the doctor (or nurse) in the egalitarian accomplishment of their everyday work. In other words patients with particular characteristics are regarded as presenting particular technical problems of practice. Such patients may for example be prescribed more medication than supposed necessary, be investigated excessively and be referred for specialist opinion more often¹⁶⁷. Furthermore they often attend frequently and so generate much “unnecessary” work. The second perspective, a sociological one, sees these evaluations as problematic for the patient in that they may prejudice the care they receive. The interest here lies in concern about professional dominance. Medical care is seen to be differentially provided to patients depending on their illness, age, social class, occupation, attitudes and behaviour¹⁶⁸.

Properties of moral evaluations of patients

Overwhelmingly, research in this area has focussed on negative evaluations of patients or on the negative emotive responses they invoke. The difficult^{167;169}, deviant¹⁶⁸, disliked¹⁷⁰, problem¹⁷¹, hateful¹⁷², or heartsink patient¹¹⁰ has made many appearances in the literature around doctor-patient relationships. Indeed

research from the clinical perspective has been characterised by the unflattering labelling of certain patients exemplified by Groves' categorisation of hateful patients into clingers, demanders, help rejecters and self destructive deniers¹⁷². Authors have identified patient characteristics associated with such negative evaluations¹⁷³. Identified characteristics have included demographic variables such as being female, being older and being of lower social class; clinical features such as psychiatric illness, personality disorder and chronic disease; and behavioural traits including high use of health services reflecting what is seen as abnormal illness behaviour. However characteristics have not been consistently ascribed across studies. As Gerrard and Riddell point out the patients one doctor denotes as difficult are not necessarily the same as those identified by another doctor¹⁷⁴. This discrepancy is seen to reflect the needs and personalities of different doctors. Inexperience¹⁷⁵, greater perceived workload, lower job satisfaction, lack of postgraduate qualifications and lack of training in communication skills¹¹¹ have been associated with doctors reporting more difficult patients.

Much of the literature about problem patients has often gone on to describe devices and strategies for doctors to cope with them. Solutions have been proposed, including doctors using their own negative feelings as important clinical data about the patient's psychological state¹⁷², sharing the "burden" of care with others¹⁷⁴ and developing a more appropriate focus for any intervention^{176;177}.

The example of "heartsink": changing interpretations of the phenomenon

In the specific field of general practice the epithet of "heartsink" has fallen into common usage to describe a particular group of patients. The research around the "heartsink patient" exemplifies the bi-modal approach of describing the

characteristics of patients attracting such an evaluation, coupled with identifying educational and training solutions to the problems they present for practitioners. "Heartsink" was a term coined by O'Dowd to encapsulate the feelings invoked in practitioners by a group of patients in primary care¹¹⁰. O'Dowd described this group as "a disparate group of individuals, often with serious medical problems, whose only common thread seemed to be the distress they caused their doctor and the practice". O'Dowd's approach to researching this phenomenon was to regard it as objective, and as a technical problem of practice for which solutions should be sought. He proposed solutions in the form of enhancing understanding of the patients and sharing responsibility for them through discussion within the primary care team. Other approaches have focused on developing skills and strategies to be used by the doctor in the consultation, whilst some authors^{169,112} have reported interventions designed to help practitioners "survive" or cope with their heartsink patients.

At its outset the foregoing research accepted an objective view of the heartsink phenomenon. However as research in this field has progressed the objectivity of the phenomenon has been challenged and alternative interpretations have been proposed. Butler and Evans revisited the heartsink phenomena 10 years after O'Dowd first described it¹⁷³. They assert that the practitioner's experience determines the status of a patient as heartsink, not merely the behaviour the patient exhibits. They suggest that because the evaluation is "one person's reaction to another person" both doctor and patient must together be regarded as the locus of the characteristic. They conclude from their work that the heartsink phenomenon is located in the doctor-patient relationship and that focussing on the doctor or patient alone is likely to be of limited value.

It is unlikely that the heartsink phenomenon is materially different from any other moral evaluation of the patient. Taking a social constructionist view of such evaluation leads me to the same contention as Butler and Evans, that moral evaluations of patients by doctors are never objective phenomena but that they arise from relational issues. Practitioners' moral evaluations of patients are constituted from their reaction to the patient in the context of what they know about the patient. In other words, the characteristics ascribed to the patient by the doctor are not intrinsic to the patient but are based on the doctor's experiential reaction to them and their behaviour. They therefore represent judgements that doctors make about patients and as such are inexact and subjective. Irrespective of the detail of the evaluation, its parameters and purpose are likely to be shared by other moral evaluations. The analysis offered here therefore takes as its basis the notion that the moral status of the patient is not an objective phenomenon but is used by the general practitioner to help make sense of the consultation, his actions within it, and his feelings about it.

What evaluations were evident in this study?

Earlier in this chapter I suggested that evaluations of patients by doctors have tended to merit research when the attributes of the patients have been perceived as problematic for doctors in the course of their everyday practice. This has certainly been the case with the research about the heartsink patient in general practice. As a result evaluations of patients which have not been perceived as problematic for the conduct of doctors' work have not been extensively investigated.

In this study no a priori evaluation of the characteristics of any patient had occurred. Indeed neither patients nor moral evaluation of them were the prime focus of the study. Rather discussion about patients took place in the context of doctors' accounts of the satisfaction they experienced from specific consultations. Moral evaluations of patients were revealed in these accounts and seemed to be important in doctors' experiences. Since patients were not already designated as problematic in any way, positive evaluations of patients emerged from the data as well as negative ones, although positive evaluations were less prominent in doctors' accounts and the ambivalence of many evaluations was revealed.

Sometimes evaluations were explicit in accounts with doctors describing patients as for example "manipulative", "juvenile", and "dependent", and sometimes they were implicit in their accounts of patients' behaviours or actions. From the data it was apparent that doctors frequently interpreted the perceived characteristics of patients with whom they were consulting and commonly arrived at an evaluation of that patient that adjudicated on their moral status.

Moreover the evaluations of patients that emerged from the study were orientated towards the specific social context of the general practice consultation, where there are socially prescribed roles and responsibilities for both patient and doctor. The extent to which a patient's behaviour was perceived to deviate from these culturally defined norms was important in the evaluative process. Hence the evaluations were generally, but not exclusively, predicated on an interpretation of "patient-role" related behaviour. Furthermore there is a degree of consensus about the range of differences in behaviour deemed tolerable and analysis of the data reveals relatively consistent parameters for doctors' evaluations of patients.

Evaluations were rarely as clear cut as ascribing patients as good or bad. A number of attributes contributed to the overall evaluation of each patient's moral status and this analysis suggests that doctors rarely adjudicated on patients on the basis of one characteristic but rather interpreted each attributed quality in the context of other qualities. The constellation of criteria used in the evaluation of each patient were not necessarily constant but were fashioned by what was known about each patient and how doctors came to know them (see chapter 6). However broadly speaking the criteria that were implicitly adopted related to aspects of the patient's character as a person and to their qualities as a patient. Sometimes these were intertwined. The following section reflects upon the parameters by which the moral evaluations evident in this study seemed to have been made.

Parameters of moral evaluations of patients

Worthiness as patient

Doctors' accounts suggest that they appraise how worthy the patient is as a patient. This appraisal relates to the extent to which the doctor perceives the patient to be deserving as a patient. This is often tied into ideas about legitimacy of patient-hood and is founded primarily on the doctor's views about either the reason for the patient seeking medical help, or about the illness from which they are suffering. In terms of conferring legitimate patient status, definable physical conditions are privileged above unexplained symptomatology, and psychological or social presentations. Furthermore patients whom doctors believe to be indisputably suffering are considered more worthy than those who present with complaints considered trivial or whose distress is contentious. Again, undisputed

suffering tends to be imputed more readily in patients whose problems have been biomedically formulated than in those whose suffering is more existential.

For example here the doctor admires the stoicism demonstrated by a 63 year old patient, whom he has been seeing for a number of years, in the face of deterioration in his physical health. An existing sound relationship and an unflinching belief in the reality of the patient's distress underlie his positive feelings about the patient.

"He's a chap who's got really quite bad coronary artery disease. He's got angina, he's had several MI's in the past and he has seen cardiologists many times. He's on maximal anginal therapy and they've offered him a bypass but he's not keen on a bypass and they think he is a poor risk for bypass surgery anyway. So he is kind of living on the edge in a cardiac kind of way and reasonably worried about it but he is stoical in the face of that and he just puts up with it....But recently he's had more problems and underwent a haemorrhoidectomy quite stoically in the Royal about four months ago, and he had an awful time after that because it was so sore he couldn't move his bowels at all and he ended up being given lots of laxatives and really was horrendous for about a month and that's now healed up, and then when he was just getting over that he had a bout of bad shingles, thoracic shingles which he required a lot of pain killers for as well, which then made him more constipated again. So in the last year he's been through an awful lot of stuff. (GP1)

Physical suffering is most legitimate when it arises from definable organic disease. Indeed patients who present personal, social or "spiritual" suffering in physical terms often have their legitimacy questioned, particularly if they have difficulty co-operating with psychosocial enquiry. For example this doctor evaluates this patient as "difficult" and the doctor's account alludes to the patient's resistance to a psychosocial approach to her problems.

“ I think possibly the theme about her husband I hadn't appreciated (before). I think that might be something we could talk about further in the future, that might help but I'm not sure whether she would.....I think she sees things very physically and I'm not sure she would think that there might be home stresses that make the headaches worse.” (GP4)

Perceptions of patient-hood and its legitimacy are intertwined with doctors' perceptions of their own roles and responsibilities. The reciprocity of doctor and patient roles within the consultation means that patients experiencing conditions which fall outside the perceived limits of doctors' responsibilities⁹⁹ are less likely to be considered worthy than those whose conditions lie squarely within those limits.

Competence as a patient

Doctors' accounts also suggest that their assessment of a patient's competence contributes to the moral status they attribute to them. Again this assessment is primarily of their competence in the role of patient rather than of their competence in life more generally. It refers to the doctor's perception of their ability to manage, in some form, their health and illness, or to be a partner in this enterprise. This doctor's account of a 28 year old single mother is typical of patients whose competence is questioned

“Yes, I think that's a difficult heartsink patient who comes, I think she probably came late, she always usually comes late and is very frustrating. She's got very difficult social circumstances as far as I know, and I do feel quite sorry for her, but she always comes with lots and lots of problems, she's always late for the consultation, and has responded at times quite well to antidepressants but then stops taking them and then all of a sudden just comes back with multiple problems again. She might not be one of those people ever able to get any better.” (GP10)

Her competence is questionable not primarily because of her non-completion of treatment, but because she is seen not to be purposeful in pursuing her own health because of the effect of social factors outside her control.

Responsibility as a patient

This relates to the doctor's adjudication on the way in which patients use health services. An implicit code of responsible and judicious use of services seems to be in operation. Perceived contravention of this code lays the patient open to charges of irresponsibility. Furthermore patients who are perceived to wilfully fail to comply with medical instruction or who are not motivated in respect of their health are susceptible to charges of irresponsibility. Here this doctor is describing a drug abusing patient's chaotic use of health services and medication.

"I could see that he'd given the previous GP the run around. She was giving him monthly prescriptions for the (dihydrocodeine) continuous and then one hundred thirty (milligram)s just whenever he was asking for them and there was one housecall where he was obviously withdrawing and a locum felt obliged to give him some more but it is chaotic."(GP3)

A similar evaluation has been identified elsewhere by researchers examining doctors' work with alcoholic and drug abusing patients^{107;178}.

Trustworthiness as a patient

Responsibility as a patient is linked to perceived trustworthiness. The trustworthiness of a patient relates to the doctor's perception of the patient's motives and to the patient's personal responsibility to the doctor. Once again an implicit code appears to be operating which recognises that doctors and patients

have legitimate expectations of each other and of how the other will behave in and use their relationship. The extent to which the doctor perceives the relationship between himself and the patient to be one of mutual trust is an important property of the evaluation he makes of the patient. When doctors mistrust the patient and their motives for engaging in the interaction, as is often the case with for example drug abusing patients, they necessarily evaluate the patient negatively. Here this doctor is talking about his mistrust not of a drug abusing patient but of a woman with pain in her pubic symphysis.

“ I always feel slightly unhappy, I almost feel I should have a chaperone with her. I’ve known her for years and she always comes with complaints of a nature where it’s with her bladder and stuff. She’s had frequent infections and she’s always got problems around here, sort of, I end up having to examine her down there. And it’s like ‘what on earth’s this?’ you know it’s like ‘what’s she going on about now?’ and I wasn’t very clear from the history, I feel a bit embarrassed talking about it actually, I often keep thinking ‘Is there a sexual thing going on her or something?’” (GP14)

Interest as a patient

The extent to which the condition the patient presents to the doctor is interesting to the doctor can influence the evaluation the doctor makes of the patient. A condition or presentation may be interesting because it is clinically rare, or because it is in an area in which the doctor has particular expertise or interest, or because the doctor perceives a particular challenge in the patient’s presentation. For example:

“I’ve never dealt with anybody who uses cannabis to that great extent. I wasn’t sure what the community drug problem service was going to be able to do for him if anything....it was interesting to meet him.” (GP8)

Personal characteristics of patients

As well as conforming (or not) to social norms patients and doctors bring personal idiosyncratic attributes into the consultation. Aspects of the patient's personality can affect the process of the consultation. These are variously and inconsistently revealed to doctors because of the specific social context in which doctors generally encounter patients, but are implicated in the overall moral evaluation the doctor makes of the patient.

In summary doctors' evaluations of patients emerged because they were important in the way doctors experienced and accounted for their routine consultations. The evaluations are predominantly related to the expectations doctors have of patients in their role as patients, although personal characteristics displayed by patients in the clinical transaction also play a part in determining the doctor's evaluation of their moral status.

The remainder of this chapter addresses two issues. First what is revealed in doctors' accounts about the process whereby moral evaluations of patients take place. Second, the purpose and utility of these evaluations for the doctor in the conduct of their work and in their interviews with me.

How are moral evaluations of patients formed?

In their accounts doctors often expressed their evaluation of a patient's moral status as a self-evident fact. However the context within which most of these evaluations are made is the doctor-patient relationship, and from doctors' accounts it was clear that patients evoke feelings in doctors in the context of their interactions. Consultations that evoke emotions, especially strong emotions, in the

doctor constitute the circumstances that shape the doctor's subjective evaluation of the patient. However the relationship between these evoked feelings and evaluations is not simply linear, to some extent it is iterative: evaluations can be taken into particular consultations and can explain (or be used in accounts to explain) evoked feelings, or evaluations can arise out of de-novo feelings evoked in consultations.

The following sections examine the contexts in which feelings are evoked in doctors, judgements are made by them and evaluation of the patient's moral status arrived at. Circumstances within and without the consultation are considered along with the work done by doctors to construct the moral status of their patients.

Circumstances of consultations

In the previous chapter I have suggested that doctors experience consultations positively if they are able to solve a patient's problem or alleviate their suffering in some way. Their capacity to do so is reflected in the feelings they are aware of in the interaction. Doctors, for example, often described a sense of powerlessness in their accounts. Emotions underlying this seemed to include frustration, inadequacy, and irritation. Patients in consultations generating such emotions were generally evaluated negatively. For example this doctor is talking about a consultation with a 40 year old woman with medically unexplained symptoms who "had already tried everything that is medically feasible for the kind of thing she was talking about". He says of her:

"This woman is very very dysfunctionalShe is somebody who comes to see me on an almost weekly basis and who has very little obvious wrong with her whose main problems are almost entirely psychological and she has several good reason, reasonable reasons for having psychological illness but denies them and somatises everything. She has a very dependent personality and very juvenile, manipulative to an extentbut mainly dependent." (GP1)

Patients, such as this, who appear to doctors to rely on medicine to supply the identity and character of personal suffering⁹³ and seek salvation through medical intervention, evoke powerful emotions in doctors which fuel the negative evaluations doctors make of them.

In contrast when doctors felt in control in consultations, emotions associated with this feeling included confidence, feeling at ease and feeling useful. Patients in consultations where doctors experienced such positive emotions were more likely to be evaluated positively. Here this doctor is talking about a consultation with an elderly woman with cardiac problems.

"Well partly just the confidence thing that I felt in that consultation that what I was doing was the right thing. And I had a good grasp of everything that was going on in her case. So I felt confident and that reassured me because of my, albeit possibly self perceived, lack of confidence in a lot of consultations and in a lot of situations. And secondly just because this was somebody I knew and somebody I cared for, somebody that I like and I felt that I was helping her. I just felt pleased that I was doing something for somebody that I wanted to help." (GP1)

He had very positive feelings about the consultation and is fulsome in his regard for her, in the context of feeling confident about his actions and being able to help her.

Positive evaluations are more likely to arise out of "mutually faced" experiences rather than simply shared experiences. In other words situations where the social

distance between doctor and patient is narrowed in the consultation for whatever reason and the doctor is able to empathise more easily with the patient. Narrowing of social distance seems to occur more readily in some circumstances than in others and the rationale for some evaluations of patients lies predominantly in the situation that allows the properties of the evaluation to be revealed. Significant events have the impact of reducing social distance between doctor and patient and such exceptional circumstances are more likely to evoke powerful feelings in doctors than routine ones. This doctor is talking about a consultation with a patient she had met for the first time who turned out to have had a myocardial infarction.

“ I think it was a bit of everything. Delightful woman, everybody's granny I think, yes she was, very nice lady. Interesting medical problem with long term implication because you think 'what will this lady be like in six months, if she has had an MI will she be able to manage at home. You think about all these things and that's why you phone when they are discharged and you know all those things go through your mind..how will she get to hospital?'” (GP2)

Interestingly such evaluations born out of exceptional circumstances provide a context and meaning for subsequent routine everyday work.

Relationships between doctors and patients not only become meaningful in the context of significant events but also in the context of longevity. A long history between patient and doctor narrows social distance and provides a context for subsequent significant events.

Circumstances outwith the consultation

Whilst this study focused on a particular interaction - a patient's consultation with a doctor about their own health - observation of the recorded consultations and

analysis of the doctors' accounts made clear the impact of other contact between doctor and patient upon the consultation in question. Relations between the doctor and patient in circumstances other than those pertaining to their own health, for example in respect of the health of a child, spouse or parent, were important in the way the doctor viewed the patient.

For example this doctor is talking about a 72 year old lady with ongoing cardiac problems who had presented to her with a recent increase in breathlessness. Her evaluation of the patient however has been arrived at in the context of the terminal care of her husband.

"Yes, I like Mrs Sutton. She's great. And she doesn't have very high expectations which she really should but I hope she's not worrying as much as she should about her heart because her rate is just getting slower and slower, and I think just by virtue of being a female GP I don't see a lot of cardiology so really I'm not that certain what to expect. And I get the impression that the cardiologists initially didn't want to see her just because her rate was slow. They were wanting her to have symptoms. Then when she was starting to get a bit breathless I sent her back and the rate was a bit slower, but they were really thinking blackouts. I really hate this idea that this dear old lady who's nursed her husband for years and years, and I used to visit regularly till he died, is going to have to collapse before anyone is going to do anything." (GP3)

The circumstances shaping the doctor's perception of the patient and her chronic illness are the shared care they offered in the patient's husband's terminal illness. The doctor has judged the patient's behaviour as a person in these circumstances as decent and deserving and has thus accorded her the positive moral status of "great" and "dear old lady". Once again it is clear how this evaluation, made evident by the exceptional circumstances surrounding the death of the patient's husband, continues to provide the context and meaning for the ongoing routine care.

It was also apparent that sometimes patients evoke feelings in doctors because of how the doctor views the patient's interactions with people other than them for example receptionists, pharmacists, other doctors and other health care professionals. For example this doctor is talking about a patient who had relatively recently registered with her.

"I just don't feel I'm getting to the bottom of her problems at all. In the background of that she's a lady who has a chronic back pain which she's had for years and taking a lot of analgesics for her back pain which she had long before she became my patient. She's not been my patient very long. And I just don't feel we ever get anywhere near solving her problems. And she's such an unhappy lady and she comes and she often has disputes with the pharmacist, disputes with the receptionist." (GP4)

In this instance the moral status attributed to the patient does not derive entirely from the doctor's personal interactions with her but partly also from the doctor's knowledge and perceptions of the patient's history within the health service more broadly.

In this study interactions at a personal, rather than professional level only rarely seemed to have bearing on the doctor's evaluation of the patient. In other settings for example in rural and remote areas, such interactions may be more common and contribute more significantly to the doctor's evaluation of the patient.

The analysis offered thus far in this chapter holds that the characteristics ascribed to patients by doctors are not intrinsic to the patients themselves but reflect the practitioner's reactions to them. The feelings evoked in the doctor depend upon the way the doctor experiences the interaction(s) between them. By and large, positive feelings were associated with positive evaluations of patients, and negative feelings with negative ones. This might suggest that in terms of the evaluations made of patients the practitioner is relatively impotent - a victim of his own emotions.

However further analysis of my data suggests this is not often the case and that the doctor is often rather more instrumental than this in evaluation. In previous studies about difficult patients, authors have recognised that not all patients exhibiting the described characteristics evoke negative responses and have similarly concluded that the practitioner is part of the problem or difficulty. Nevertheless the part of the practitioner has not been extensively explored. Analysis of the data in this study supports the idea that the doctor constructs the moral status of the patient in interaction with the patient.

Constructing the patient's moral status

The notion that doctors construct the moral status of their patients is upheld by accounts in which doctors identify characteristics of patients that have often been perceived negatively, yet they evaluate the individual patient positively. This doctor is reflecting on a 63 year old woman who attends frequently (at least weekly) with perpetually unresolved chronic pain and intractable social problems.

"I just find, she's just brilliant. She is just an amazing woman. The first letter in her case notes volume one says 'this blond vivacious and attractive woman presented to me'. That's the same woman and if you read through what's happened to her in her lifeand if you go through the catalogue of her life you know where she is coming from and it all makes sense when you see what's happened to her but if you saw her a once off you'd think she was a very mentally dull poor soul." (GP2)

Through a process of reflection and re-consideration the doctor has produced an alternative interpretation of the patient which attributes her as "brilliant" and "amazing". This evaluation lends legitimacy to her patient-hood which is threatened by her behavioural characteristics.

In other situations the worthiness of the patient is not in dispute yet their responsibility as a patient is in doubt. For example this doctor has described the attributes of this 86 year old negatively in the context of her role as patient yet has constructed her overall moral status positively.

“Mrs McKinnon is a retired hospital matron and is a fairly bloody minded old cuss basically and em, doesn’t like hospitals and doesn’t like being referred and doesn’t like tests and doesn’t like pills and keeps saying fairly loudly that it’s high time she was dead.....The drop attacks which still haven’t been diagnosed are annoying her particularly because they’re making her frightened to go out and she likes to go out to the local shop and I quite admire the fact that she is bloody minded and so forth and doesn’t like all these things and doesn’t like doctors and is rude to doctors and so forth.” (GP9)

In such instances favourable re-interpretation of characteristics in a personal context, as opposed to a patient context, occurs to produce a positive evaluation. Although evaluations of the perceived personal characteristics of patients outside their role as a patient were less common in doctors’ accounts than evaluations of their patient status, they seemed to be important. They occurred against a background of the doctor’s own attitudes to life and work. Here this doctor is talking about an 82 year old man recently diagnosed with angina.

“ He’s an amazing old chap. He’s a hairdresser. Well he now only has one shop, he used to own five shops in and around Edinburgh and still works in the one in Bellenden, various other family members run some of the other ones. The feel-good is there, he’s the sort of person that makes you feel good about life because you think ‘gosh, he’s got a bit of angina but largely in his 80’s he’s pretty fit and running about’.” (GP7)

The doctor’s positive regard for the patient arises not out of the historical context of their relationship but out of admiration for the way he perceives the patient conducts his life and is confronting his current ill health. This is confirmed by the positive emotional reaction the doctor experiences in response to this.

Furthermore, the patient's perceived characteristics and qualities are congruent with the doctor's own value system and this is reflected in the doctor's positive regard for him. As the doctor says,

"I think, (it) must be my Scottish Presbyterianism. I think I admire people who – not put up with awful things and don't come for help but people who generally confront their illness or their condition and try and you know challenge it, try and make a go of it and I think he does. He has angina but I don't think he's going to stop working or down tools. He's going to accept it and get on with it I suppose. Yeah I like people like that, or I admire people like that."
(GP7)

The analysis presented thus far supports the notion that doctors morally evaluate their patients, and that these evaluations can be positive as well as negative. Furthermore the evaluations made are shaped by the interactions between doctor and patient. Examination of the doctors' accounts confirms that evaluations of patients are disclosed in relation to descriptions and accounts of the conduct of consultations. Furthermore in these accounts, and the experiences they depict, such evaluations can be seen to have purpose and utility for the doctor.

Purpose of moral evaluations

Examination of the doctors' accounts suggests that their moral evaluations of patients have intent both in the conduct of consultations and in the construction of accounts of consultations in the interview. The analysis that follows here suggests that the moral evaluations of patients evident in doctors' accounts have two distinct purposes: they are both instrumental and explanatory. First, they seemed to shape the nature of individual consultations. Indeed the analysis of the interview data in this study suggests that the practice of medicine in the general practice setting can be influenced quite profoundly by the doctor's adjudication on the patient. Second the evaluations seemed to be central to the way doctors

accounted for aspects of the experience of consultation in interviews and were decisive in maintaining the doctors' credibility in the interviews. This second purpose sees evaluations as a means by which doctors account for their capacity to alleviate suffering in the consultation, explain and justify their actions within the consultation, and explain their emotive responses to it.

Evaluations as instrumental

Taking the first of these purposes, evaluations of patients can be regarded as instrumental in shaping the conduct of consultations because they help to define the challenge presented by each consultation. The perceived site of the challenge in the consultation then facilitates and motivates the decisions and actions of the doctor

Locating the challenge in each consultation

In chapter 4 I described how perceiving success in consultations appears to be conditional on the doctor achieving a complete assessment of the patient's problems. General practitioners work with, if not within, a biopsychosocial framework of health and illness and this complete assessment involves the doctor in disaggregation and reorganisation of a number of inter-related strands in the patient's presentation. Doctors tend to re-organise the various aspects of patients' problems into biological, psychological and social domains^{xvii}. In any consultation the doctor will perceive greatest challenge from aspects of the patient's problem

^{xvii} Alternatively clinical, individual and contextual levels as Fehrsen and Henbest described in their expansion of the patient-centred clinical method¹⁹⁸. For the purposes of this analysis the precise framework is immaterial. What is important is that patients' presentations are seen as multi-faceted.

located in one, more than one, or all of these domains. The doctors' accounts of consultations indicate how they have perceived and located the challenge(s) in each consultation. Again although doctors often described these challenges as entirely objective, they are generated out of unique interaction between the practitioner and the individual patient, and as such are subjective. Defining the predominant challenge in each consultation involves not only the doctor understanding the nature of the problem the patient presents, but also understanding the nature of the patient. Therefore doctors use their moral evaluations of patients to define and locate the challenges in each consultation. This also highlights that the evaluations of patients made by doctors are orientated specifically towards their social context, that is the doctor-patient relationship in a general practice setting, and therefore cannot be extrapolated to other social settings.

Despite disaggregation of patients' presentations in the process of assessment the domains of their problem remain interdependent. The site of the main challenge for doctors in routine consultation can shift from one domain to another. Indeed there appears to be a hierarchy of domains. The challenge of the consultation can usually only be located primarily in a clinical or biological domain when problems in psychological and social domains have been addressed or excluded.

Doctors generally evaluated patients as unproblematic in consultations in which they perceived the main challenge presented in the consultation was in the clinical domain. For example this doctor perceives the challenge confronting her to be whether to prescribe hormone replacement therapy for a patient experiencing menopausal vasomotor and urological symptoms in the context of a past history of breast cancer. This biological focus to the consultation was permitted because she perceived no challenge in other domains of the patient's presentation.

“She had her problem which was quite well defined, we’d already chatted about it before and I was able to give her something which was probably going to substantially help her symptoms and she was quite happy and knew what the likely problems were and was happy with the way things were going.....This woman came over as a very pleasant individual who came in and had a problem which you could very much kind of empathise with, and you actually felt you had provided a solution to that...and she was clear where she was going.” (GP18)

As here, when locating the challenge of a consultation in the biological domain the evaluations the doctors made were often positive. Patients who were regarded as competent allowed the doctor to focus their efforts in the biological domain. Conversely in some consultations there was a biomedical task to be accomplished yet an explicit negative evaluation of the patient was apparent. The negative status accorded to the patient leads the doctor to perceive that the greatest challenge lies not in the biological domain but elsewhere. Locating this challenge relies on the doctor’s evaluation of the patient. For example, this doctor has a biomedical task to accomplish in terms of diagnosing and treating a young girl’s cough, but he has located the challenge of the consultation elsewhere - trying to get the girl’s mother to accept his way of thinking about her daughter’s symptoms. This challenge is configured because of the way he has evaluated the girl’s mother.

“That girl’s mother tends to be very negative and not complaining but you just perceive that often what you are attempting to do with her children isn’t good enough.....I’d seen her frequently in the past but I felt we might be heading for trouble, that we weren’t going to get anywhere.”(GP7)

The challenge perceived by the doctor is at the individual level of addressing the mother’s ideas and expectations about her child’s health.

Similarly this doctor is talking about an elderly lady who is the main carer for her husband who has Parkinson's disease. She has hypertension and this is the expressed reason for the consultation. However the doctor's evaluation of her is that,

"She is a lovely lady but she's become really anxious in the last few years. I think he's a big burden to her at home and although she's very fit she's a hard time coping with him..... And it may be that all this fuss over (treatment of her hypertension) is to say 'Look, pay attention to me, I've got a problem here as well'." (GP7)

He locates the challenge in this consultation in the contextual or social domain despite the presence of clinical tasks in relation to management of her hypertension. He does so on the basis of her perceived anxiety (which here is a moral evaluation rather than a clinical diagnosis) and stress in relation to her role as a carer.

Sometimes there is mismatch between where the doctor and the patient locate the challenge. This is seen most commonly in situations where the doctor and patient do not share explanatory models for the patient's problem. Such mismatch has been described by others in relation to specific conditions such as low back pain¹⁰⁸, and somatisation disorder¹⁷⁹. Concern to preserve the doctor-patient relationship leads the doctor to collude with the patient in focusing action in the consultation in the domain determined by the patient. This promotes negative feelings in the doctor and fuels negative evaluations of the patient.

Determining action

Identifying the site of greatest challenge in a consultation suggests the specific domain(s) within which action should be focused in that particular consultation.

This serves to crystallise the perceived options and choices the doctor has in terms of interventions. At a clinical level doctors expect to be able to make a diagnosis, to explain symptoms and to effect change. When biological interventions are either not possible or ineffective, moral evaluations of patients gain prominence in their accounts firmly locating the challenge of the consultation in individual and contextual domains, and determining appropriate actions. This doctor is talking about a patient with a disputed diagnosis of epilepsy. She has attributed characteristics to him that in other studies have described problematic patients: difficulty defining the clinical problem; failure to conform to the clinical regime in terms of keeping appointments and complying with medication. Nevertheless she constructs him not as problematic but as interesting. Furthermore her evaluation of him locates the challenge in the consultation in the individual domain, and hence determines her actions in confronting him about non-compliance with medication.

“He’s just a very interesting individual and I suppose to anybody else the type of consultation I had with him would be very unsatisfactory but on the basis of previous consultations we’ve had in fact I suspect they’re improving because I am challenging him more and saying you’re not taking it, what’s the story here.” (GP2)

Accepting inaction

The repertoire of interventions available to doctors in individual and contextual domains is limited given the configuration of their knowledge and skills. Consequently such evaluations sometimes merely have an interpretative purpose. They enable the doctor primarily to understand rather than necessarily intervene in the patient’s problem. In many cases the doctor is then able to accept inaction as inevitable and to justify inaction. For example this doctor is discussing a consultation with a 28 year old woman who suffers recurrent depression. The

doctor concedes the fruitlessness of intervention in the clinical domain because she has located the challenge of the consultation in the contextual domain.

“I’m not sure that anti-depressants or psychologists are really going to advance the situation tremendously forward. Now it may be that nothing can, I’ve a feeling there are a lot of family things over which we have no control. I didn’t feel it was particularly satisfying in that the consultation wasn’t going to make a big difference to her but on the other hand it wasn’t really unsatisfying in that nothing negative happened.” (GP4)

Her expectations of the consultation were configured by how she understood the patient and her problems and this allowed the doctor to accept inaction. It also allowed her to reject conventional biological approaches to depression because they were unlikely to address the challenge of the consultation which she perceived lay elsewhere in a social or contextual domain.

Informing choice of intervention

Beyond situating the challenge in the consultation and determining the site of any intervention, the evaluation of the patient also has purpose for the doctor in choosing between possible interventions. Where two or more approaches to a patient’s problem are possible, the doctor’s evaluation of the patient is seen in their accounts to be influential in their choice of option. This was equally true in cases where the problem was formulated in clinical terms as in situations where the problem was situated in individual or contextual domains. Examination of the doctors’ accounts revealed reports of instances where clinical decisions about investigation, treatment, follow-up and referral had been founded not only on biomedical need but also on the evaluation of the patient.

For example this doctor is talking about a 39 year old woman in the second trimester of her second pregnancy. Her first pregnancy had been complicated by pre-term delivery and the baby had spent a period of time in the special care baby unit. There were complications in the current pregnancy with persistent vaginal bleeding. The doctor says:

“The time I’d seen her before this consultation she’d been quite low in mood and I think I was worried that it was just going to continue like that all during her pregnancy. And this consultation she was just a lot better, she was a lot more upbeat. And I suppose partly the reason I mean I so enjoyed, I liked the consultation because I knew her and I’ve quite a background of a reasonably good relationship but also because she is not, she was sort of fairly sensible and well balanced. She wasn’t wanting to just kind of rush to hospital. You know she just wanted to go with the flow and see what happened,She wasn’t pressurising me into organising weekly scans for her, she was just being so sensible about it.”
(GP5)

The doctor’s decision not to investigate repeatedly this potentially serious symptom in pregnancy was based in some part on her evaluation of the patient as sensible and well balanced. A different appraisal of the patient might have led to different action.

Once the challenge presented by the patient to the doctor in the consultation is located, the doctor’s evaluation of the patient has further purpose in establishing the doctor’s expectations of being able to meet the challenge.

Evaluations as explanatory

An alternative interpretation of doctors’ accounts suggests that doctors explain some medical decisions through reference to the moral status of the patient. In this way some apparently idiosyncratic decisions are justified and the doctor

safeguards his presentation as a competent and caring professional. As this doctor says,

“And so, he’s just one of those likeable guys that I suppose I’m making it easy for myself by getting him to come back but on the other hand I do feel genuinely that he’s so stoical that if you were to just say “Off you go and just phone me if there’s a problem” he probably wouldn’t phone you know unless he was having a heart attack or something.” (GP7)

The nature of some consultations means it is difficult to reach medical decisions of any kind. In such situations doctors often feel frustrated and powerless and the moral evaluation of the patient takes centre-stage in their accounts of the consultation. For example:

“I suppose if we could have done something to improve the situation possibly or even if we could have talked more about the things , if there were things making her stressed at home which I think there possibly are, if we could have discussed that more fully. But eh, I don’t think we.....she’s a difficult lady really to get on with and she didn’t start with me, she fell out with one partner and had joined my list but em not an easy lady. And it may be that just interactions with her aren’t as happy as with other people. So that might colour you view.” (GP4)

Ascribing this lady as difficult justifies the doctor’s actions within the consultation. Thus the doctor is able to protect her identity as a “good doctor”. Furthermore the patient’s moral status legitimises the doctor’s feelings about the consultation.

This interpretation regards aspects of the doctors’ accounts as appeals to intersubjectivity between interviewee and interviewer. The moral evaluations of patients not only help the interviewees present and maintain themselves as credible doctors in the interview but also the interviewees take for granted that I will understand the relevance of the moral evaluation in the context of everyday practice.

The doctor's experience

The moral construction of the patient by the doctor not only reflects the practitioner's experience of interactions between them, but also it can shape the way subsequent interactions are experienced. General practice consultations rarely happen in isolation. They can often be best understood as an act in a series that is likely to continue beyond the present episode and in which the character of the actors has already been established before the present episode. The way doctors account for their feelings in and about consultations is often referential to past experiences. Consultations with patients who had been evaluated somewhat negatively in the past were unlikely to be rated as satisfying by the doctor. This doctor is talking about a patient he describes as "dependent", "juvenile", "manipulative"

"No, I find almost every consultation with her difficult from my point of view and my heart always sinks when I see her on the list and I superficially have a laugh with her but I never find consultations with her very satisfying personally. The only thing that satisfies me is if I see that there is a possibility of some improvement in her from having seen her, and there wasn't on this occasion except in the fact I had held on for one more week you know, I hadn't given up, I hadn't told her to fuck off for ever." (GP1)

Doctors were sometimes quite candid about how their experience of the consultation was influenced by their evaluations of patients. Here this doctor is talking about his least satisfying consultation.

"Come to think of it my rating of the consultation was probably based more on my overall rating of the patient rather than my rating of that consultation alone...you can't separate the two...I think I was biasing my views on what I feel about her and possibly (in this consultation) she was beginning to appreciate more what we were doing for her, that's probably on reflection." (GP10)

Nevertheless entrenched negative evaluations of patients do not always result in dissatisfying consultations. Consultations in which negative expectations were confounded were experienced relatively positively. The negative expectation is rooted in the doctor's negative evaluation of the patient. In these circumstances the tendency to catastrophise the potential of the consultation beforehand leaves the doctor relieved when expectations are not fulfilled.

" I thought it'd be terrible because of my past experiences with him and my colleagues past experiences and as you worked out he has multiple sclerosis and has had HUGE difficulties coming to terms with that. Has got very down because of it. As he put it once that multiple sclerosis that's all he thinks about now. And doctor-hops within the practice, has complained about the (local hospital's) handling of him. You know, official complaints. And I know that he expresses his dissatisfaction with me to my colleagues and vice versa. So when he's with me he doesn't directly criticise me. I know he does that when he's seeing the others. And that was a very difficult consultation but at the end of it I felt better than I thought I would." (GP6)

Here the doctor's evaluation of the patient is based on the patient's past behaviour and it influences both his expectations of the consultation and his emotive response to it

Conclusion

At the beginning of this chapter I stated that concern about professional dominance and the role of the doctor underlie sociological interest in moral evaluations of patients. Sociologists have argued that patients are treated differentially according to attributed characteristics, and when these characteristics are undesirable the patient's care is prejudiced. The analysis presented in this chapter also suggests that care is delivered differentially to patients on the basis of moral evaluations. However this analysis leads me to suggest that this is not always disadvantageous. Although evaluations are rarely

morally neutral, they are not always judgmental and in fact in many cases they might be an inevitable consequence of the context in which general medical care is delivered, that is a complex interaction between social and biological concerns. Furthermore they may also be necessary for the conduct of general practice work given the essentially moral nature of this enterprise.

Nevertheless analysis of doctors' accounts of consultations with patients to whom they had ascribed positive characteristics revealed a clear biomedical bias in the diagnoses accorded to them by doctors. Patients who presented with physical symptoms but defied biomedical diagnosis, and whose problem doctors commonly ascribed as psychosocial, were much less likely to attract positive moral evaluations. This is perhaps unsurprising if as seems possible the doctor sometimes constructs the moral status of the patient to protect his own moral status as a "good doctor". In the previous chapter I have described how doctors' evaluations of themselves are predicated on a view of the role of the doctor that privileges therapeutic utility. Despite the centrality of the psychosocial sphere to presentation in general medical practice, the interventions available to doctors are still pre-dominantly in the biological sphere. Hence success is more likely in this sphere, confirming doctors' evaluations of themselves as good doctors and reciprocally the patients as good patients. Lack of reciprocity between the roles of doctor and patient often suggests the challenge of the consultation lies outside the biological sphere. Patients are often negatively evaluated not because the doctor sees the challenge of the consultation in individual or contextual domains but because it is perceived the patients are unable to demonstrate the necessary level of psychosocial accomplishment to achieve reciprocity of roles.

Summary

This chapter has focused on the part of the analysis that suggests doctors' evaluations of their patients' moral status are important in their experience of consultations.

Moral evaluations of patients have attracted interest in both sociological and clinical research previously. This interest has primarily reflected concern with the problems, for both patient and doctor, attendant upon negative evaluations. Negative evaluations were apparent in doctors' accounts here too but the analysis presented in this chapter emphasises that when doctors' everyday work is examined positive evaluations emerge as well as negative ones.

Furthermore the analysis presented here views evaluations not as objective concrete phenomena intrinsic to the patient but as arising out of interactions. In other words it is the doctor's experience that determines the status that they accord to patients. The focus of attention in this chapter has been on the interaction between doctor and patient in particular in clinical transactions. Doctors often do not have alternative experience outside the consultation on which to draw in making evaluations. Therefore the evaluations are inevitably orientated towards the specific social context of the doctor-patient relationship in general practice, where there are accepted norms for behaviour of both patient and doctor.

Given this latter point it is worth pointing out at this stage that the evaluations may also have arisen out the interaction between interviewee and interviewer, where the interviewee can be seen to act to demonstrate conformity in their behaviour.

Beyond this, these moral evaluations can be seen to shape, as well as be shaped by, the interactions between doctor and patient. In chapter 4 I suggested that doctors are most satisfied in their encounters with patients when they perceive they have been therapeutically useful. The data presented in the current chapter suggests that doctors use moral evaluations of patients to decide where therapeutic effort should be directed in consultations, and to inform their choice of actions. When therapeutic utility is not anticipated, evaluations have the purpose of configuring this expectation so that inaction is accepted. Therapeutic utility is most readily anticipated when patients have problems falling within a clinical domain. Patients who present problems outside of this or who defy biomedical categorisation often attract less favourable evaluations. Indeed in doctors' accounts moral evaluations of the patient often replace biomedical evaluations of their problem when inaction occurs.

In the interaction in the interview, evaluations have the purpose of legitimising the doctors' actions within the consultation. This is an important strategy for the doctor if he is to maintain credibility within the interview. Moral evaluations of patients can also be seen to help the doctor make sense of his emotive response to the consultation.

The evaluations discussed earlier take for granted that doctors have some knowledge of and about the patient. In the next chapter I will explore the idea of doctors knowing their patients, in particular the way in which doctors come to know and know about their patients.

CHAPTER 6: FINDINGS - KNOWING THE PATIENT AND KNOWLEDGE OF THE PATIENT

Introduction

In the previous chapter of this thesis I explored the moral evaluations doctors make of patients and the purpose and utility of these evaluations for doctors in the context of the accomplishment of their work and in their accounts of their work.

This chapter is about a concept that emerged as central to these evaluations and to general practitioners' understanding and experience of their work in the consultation: the idea that the patient is in some way 'known' to the doctor. This notion is an important one in a professional discipline that through much of its recent history has placed great importance on the interpersonal relationship between doctor and patient, and its operationalisation within the consultation.

In chapter two I described some of the broad theoretical approaches to the general practice consultation evident in the literature about general practice. These approaches involve quite different interpretations of doctor-patient interaction, for example consideration of the consultation as a technical problem of practice for the doctor, versus the consultation as a site for the negotiation of knowledge and power relations between doctor and patient. Nevertheless they are united by recognition that the consultation is an encounter that relies on both participants being in some way 'known' to the other. Yet, as I also revealed in chapter 2, in debates about the general practice consultation, this concept is largely, either assumed or neglected. Patients and doctors being known to each other is believed to result from the structural arrangements of general practice that encourage

continuity of care. Detailed explorations of what it takes for a doctor to “know” a patient and what it means to do so are scarce.^{xviii}

Knowledge and its context

In this study the expectation that general practitioners have that they *can and do* ‘know’ their patients was striking. The doctors who were interviewed talked about their knowledge of the patient in the majority of the consultations that were examined. This knowledge seemed to be crucial to the way in which the doctor experienced the consultation. It was clear that in the majority of consultations the doctor had a priori knowledge about the patient and that this knowledge took a very specific form shaped by the context within which it was acquired, that is the general practice consultation. Considering this more closely, the thrust towards patient-centred medicine, open and negotiative consultation skills, and the biopsychosocial model in primary care medicine all rely on the notion that the patient will provide a ‘history’ composed of more than a brutal list of medically orientated facts. This condition was reflected in the way knowledge about the patient was incorporated into doctors’ accounts. For example this doctor summarises what she know about her patient by way of brief reference to some physical, psychological and social characteristics.

“I’m conscious of the fact that she’s had a very miserable time in the run up to her hysterectomy. She had a hysterectomy at a young age for endometriosis. She’s quite a frequent attender.” (GP12)

^{xviii} Material included in this chapter has been published in Family Practice 2001, 18:501-505. A copy of this paper is appended at the end of the thesis.

The notion that general medical practice is conducted in the context of patients' lives, and that these lives are embedded in the families and communities in which patients reside, also frames the knowledge doctors have of patients. In their accounts of consultation doctors often reported biographical details of patients.

"We've had a very friendly relationship for some time, because I discovered she was a receptionist in one of the garages in Edinburgh where I bought the car from. So every time she's been in for the pill or whatever over the years we've sort of chatted about cars, you know what she does. And there was an edge to it because her family had an unfortunate experience with our practice and her father died of cancer of the kidneyand her mother worked as a receptionist but she left soon after." (GP14)

Generally, knowledge was either biomedical knowledge or biographical knowledge but sometimes included what McKeganey refers to as "ethnographic" or cultural knowledge¹⁰⁷. This is knowledge doctors have about patients not necessarily as individuals but as members of a community with certain shared socio-demographic characteristics. For example:

"One thing about our patients, none of them, well not many of them are thick." (GP6)

and

"I liked the client group, sort of the social mix, not too many demanding sort of upper class patients or social class five patients and it was a stable practice population and I felt that the patients sort of respected the doctors." (GP5)

However in doctors' accounts the distinction between these different types of knowledge, biomedical, biographical, and cultural, was often obscured. Commonly, general practitioners moved seamlessly between biomedical detail and biographical description. Here this doctor conflates knowledge about the patient's biomedical

problem (transient ischaemic attack), with knowledge about her lifestyle and life circumstances.

“Her physical health has become more of a concern recently. She is a heavy smoker, she’s a daughter who’s had a recently diagnosed brain tumour, a son who died of HIV and a husband who committed suicide. So lots and lots, a very complex history and I think she has suddenly become, with her daughter becoming unwell, slightly more aware of her own physical health, and I think you know that part of my preventative strategy with her was to try and take her on, because she’d had a TIA and she’d been assessed at the neurovascular clinic and had dopplers done.” (GP2)

Through this juxtaposing of different types of the knowledge the doctor gives the illusion of accessing something of the patient’s interior processes. So her history becomes more than a collection of facts. Hence the context of the general practice consultation and the conditions of its execution have played a part in configuring what the doctor knows about the patient. Furthermore the doctor does more than collate the information about the patient, she socially organises the knowledge she has of the patient in a way that constructs her patient-hood. In other words the facts, findings, opinions and diagnoses in this case become the practical knowledge which the doctor uses in her work. Thus the knowledge of the patient is constructed in such a way as to reflect the general practitioner’s attitude to the knowledge. Of the same patient the doctor says,

“You have to believe you can make a difference and I think I can with this lady and I’m trying to encourage her to stop (smoking) because I recognise it will improve her health.” (GP2)

Doctors are aware of the partial and biased nature of the knowledge they have about patients, and that this knowledge is orientated towards a particular view of the world.

"I know you only see a tiny little snapshot of them but if you are seeing somebody regularly over a period of years you can get to know them, you get a feel for what sort of person they are. You don't know them wholly you just know the bit that impinges on their health and the part of their health they choose to present to you which again is a smaller segment of that already small segment." (GP8)

Knowing the patient

However the perception of "knowing" the patient is not necessarily predicated on this knowledge. Plenty can be known about a patient without the doctor feeling that he "knows" that patient, and conversely, patients about whom little is known can be considered as "known". Thus a distinction emerged between what was known *about* the patient and knowing the patient as person. Furthermore, in terms of the doctors' *experience* of consultations including the satisfaction they derive, the facts that are known about patients seem less important than the way in which the facts become known to them or the way in which doctors get to know about individual patients.

The remainder of this chapter explores the ways in which doctors get to know about their patients and the different types of knowledge that result. The impact of these processes and this knowledge upon the conduct of the consultation and upon the doctors' experience of the consultation will be discussed.

Deductive and inductive knowledge about the patient

Within doctors' narratives about the experience of the consultation, accounts of two ways of "knowing" the patient were apparent.

a) knowledge of the patient that is founded upon a deductive approach. That is, the doctor formulates a hypothesis about the patient based upon initial factual

evidence of different kinds, and then seeks to confirm or refute this by line of questioning that obtains further information from the patient.

b) knowledge of the patient that arises from an inductive approach to the patient's own account. In this case despite a priori factual knowledge the doctor does not hypothesise about the patient but allows an interpretation of the patient to emerge within their interaction.

A deductive mode of reasoning about the patient results in the doctor focusing on factual or objective information, either directly from the patient, or from medical records. Whilst this information is often willingly provided by the patient, it is not spontaneously divulged. The patient grants the doctor access to this information because it is requested and believes it to be important to the conduct of the consultation. As a result the doctor gains a set of unilaterally worked up facts—medically orientated knowledge about the patient—but their interpretation is not necessarily shared with or by the patient.

“I don't mind holding on and I don't mind having superficially dysfunctional consultations with people if I can continue with them long enough to work it out. And that has helped with her, it has worked with her a little. There have been a few consultations when having seen her for 2 years I am able to talk to her about her bereavements, her turning forty and her inability to have children which are her big problems and that has possibly helped a little.”
(GP1)

Similarly,

“So it's trying to find out what goes on in their life, and again another advantage of being in general practice, particularly in a fairly tight community like this, is you can understand a lot about where they live, who they live with and who they interact with, both in terms of their family, extended family and friends....” (GP11)

This general practitioner talks about 'facts' in the context of the patient's life, and about the interpretative function through which he attributes meaning to the facts constructed in history taking. The interpretation is his own and it is not clear how this relates to the patient's interpretation. As a result the doctor has unilateral knowledge of the patient within the specific context in which he is presenting, and here this is characterised in terms of an absence of connection.

"Well it would be interesting to know what he thought actually, because he's definitely the kind of bloke that you know he seems to leave the room quite happy but you've no idea what he's thinking, certainly not on my wavelength." (GP7)

Lack of connection is not alone as a potential negative outcome of a deductive form of reasoning. When a doctor has a number of pre-conceived ideas about what information is salient in any interaction, and these ideas are antithetic to those of the patient, then confrontation is likely. This doctor is talking about a consultation with a 53 year old gentleman requiring a prescription for dihydrocodeine. The doctor's interpretation of the facts is again her own but in this instance it is abundantly clear that the patient rejects this interpretation.

"I think I was upset by his allegation that I didn't appreciate that he was a sick man and needed medical help because I do think he is sick but I think he is making it very difficult for himself to get ordinary medical help by his extraordinary manner. But again it's not entirely his fault because someone started him on all these in the first place and I think he mentioned that in a previous encounter that you know he's a victim of bad prescribing. My suggestion of having it (his prescription) daily, the only draw back is the trip to the chemist. ...He's got this young chap who hangs around him, sort of accompanies him. I mean he's also on a prescription for DFs but he purports to be very altruistic in helping the older man and sees to his needs, which I don't believe either. He doesn't look like he's the helping type really..... He is taking a lot and he is very dependent on them...He says that it's a medical problem not a drug problem and I'm not sure that really ties up with what's in our notes.I think I ought to treat him the way I'd treat anyone else (with a drug problem) and that means daily prescribing" (GP3)

An inductive mode of reasoning in the consultation involves a jointly produced account of the patient's ill health and the doctor's response. Here, the patient voluntarily admits the doctor into the inter-subjective construction of information perceived to be relevant to her ill health.

"That was the third one (consultation) that she'd been to and the first two consultations she just sat and cried for the first sort of five minutes and been in such an almost hysterical state that she'd been barely able to get her words out and she'd had these dreadful social problems – they'd moved down from Dryden, they'd been kicked out of their house and discovered they'd bought a car which turned out to be stolen property and they got arrested and held by the police and it was just a whole string of disasters and the first time she came to see me ..I mean I just felt like weeping when she finished telling me the story herself. I just thought you know how bad is it going to get for this girl, she was just a mess and there was a lot of ignorance about the hepatitis C business..." (GP8)

The doctor has few pre-conceived ideas about what information is needed or relevant but allows the salient issues to emerge from the interaction. Furthermore the meaning of these issues is jointly constructed by both doctor and patient. Thus the doctor gains a "voluntary" knowledge of the patient which allows a shared understanding of the patient and of the doctor-patient relationship to develop.

When doctors felt they knew a patient in this way, they often described a "connection" or "rapport" between themselves and the patient. This was associated with an ease of interaction which facilitated therapeutic aspects of their relationship. As this doctor says,

"I feel that we connect. We've met on quite a few occasions and I feel easy talking to her and I'd like to think she's found it reasonably easy to talk to me. She's had some psychological difficulties related to her physical problems and I've sort of, I hope, helped her with that and drawn some of that out of her which I think maybe she wouldn't have talked to some of the other doctors she didn't know so well." (GP6)

Consultations in which doctors perceived a “connection” between themselves and the patient were by and large among the most satisfying.

Impact of knowledge upon the consultation

The concept of meaningful knowledge

In any consultation some knowledge of the patient is obligatory for the doctor to be able to proceed with his work. Indeed the production of this knowledge is an intrinsic part of the work of general practitioners. Reasoning of either of the types described above can give rise to this obligatory knowledge but each type results in different interpretations of the patient. Deductive reasoning tends to lead to an interpretation of the patient as a case whereas inductive reasoning is more likely to result in knowing the patient as an “actor” in a social interaction. These different interpretations influence the subsequent course of the consultation and underpin the actions that are taken within the consultation in relation to diagnosis, intervention and negotiation.

The view that medical practice is suffused with uncertainty is commonplace in writings about clinical encounters^{15;180;181}. The uncertainties arise in relation to diagnosis, treatment, outcome and patient response. These types of uncertainties are particularly manifest in general practice where illness is undifferentiated, presented early in its course, and shot through with complex social and psychological confounders. The different interpretations resulting from different

types of reasoning about patients in the consultation result in practitioners having different relationships with this inevitable clinical uncertainty.

Impact of deductive reasoning

When a deductive mode of reasoning is foremost with a patient, the action that is taken within the consultation is primarily determined by a reading of the facts of the case. When the patient's biomedical "caseness" is clear-cut, diagnostic and therapeutic ambiguities are not often evident. However when deductive reasoning is dominant yet the patient's biomedical caseness is conjectural, diagnostic and therapeutic difficulties can ensue.

a) Diagnostic dilemmas

The diagnostic difficulties arise from poor understanding of the significance of the symptoms in the patient's world. As a result, minimisation of doubt is sought through recourse to technical procedures which are sometimes inappropriate or unavailable. For example this doctor is grappling with the difficulties surrounding diagnosis in a 71 year old woman with an equivocal history of one episode of haemoptysis.

"I don't know what it is. It is something to do with... maybe it was all body language, what couldn't be heard but could be seen, a blankness of her expression, looking as though she wasn't really understanding what I was saying and I suppose if you deal with something like haemoptysis, you're always in your mind, you can't refer absolutely everybody who has a little bit of dirty spit. It would be exceptionally reassuring if you could say everybody had a bronchoscopy or that sort of thing and I suppose it frustrates me. The dissatisfaction is in part from my professional point of view thinking is this somebody I should be referring for bronchoscopy, is this of any significance? And another part her who I found slightly vague and hard to pin down." (GP2)

The facts of the case are meagre but in the absence of any other way of interpreting the patient's problems, she is forced to rely upon them to inform her clinical decision. This leads to an aggravated sense of uncertainty. Inability to find ways of managing clinical uncertainty is unsettling for doctors and in the context of their emotive responses to consultations dissatisfying

b) Therapeutic dilemmas

This doctor is ruminating about a consultation with a 50 year old man, who has not attracted a formal psychiatric diagnosis. His knowledge of him is extensive yet primarily deductive. Hence the relationship between doctor and patient is not inter-subjectively constructed and the doctor has no insight into the patient's motivations or his interior processes. He is ambivalent about the possibility for therapeutic action within the consultation and the consultation was among his least satisfying.

"I'm not sure why he keeps coming back to see me. I think I might just say to him "Look, Mark, I really don't know why.." I think I might say to him next time "Right what are we doing?" He has a history and his mother is alcoholic and lies in bed. His father you know it's not just him, it's the family. He is a very bizarre man, who has done various things like we were phoned one day at night "can you come and see Mark?" and he's lain in bed, locked his door and cut his wrists and probably lain there for several hours because the mattress was absolutely saturated with blood and he couldn't give an account of why he'd done it, and he sort of goes into an almost fugue like state. He's a really strange man.....I have to see him occasionally because he comes and says "I can't do it anymore (community service) I'm too anxious" and I have to give him a line and I'm sort of going along with him all the time....So it's unsatisfactory when I meet him because I don't know what I should be doing and I don't know if it's a valuable thing to just keep going along with him." (GP14)

Patients with a troubled life history such as this were common in this study. They presented significant challenges to their doctors not necessarily in the realm of diagnosis – doctors were able readily to identify the lack of pathology- but in terms of disposal. In other words doctors experienced difficulties in helping the patients

resolve their problems. This was particularly true in cases where deductive reasoning was prevalent and they could find no substitute for their lack of biomedical knowledge and certainty.

c) Outcome and patient response

When deductive reasoning prevails it is difficult for the doctor to predict the outcome of the consultation in the patient's "world" and this is a source of dissatisfaction with the experience of the consultation. As this doctor says of this elderly patient,

"And you always like when you've had a consultation to have an idea what the patient will be thinking of as they go home and when they get home what they will tell their family, and I have absolutely no idea what that lady thought. Maybe I didn't use any of the right words or whatever, I don't know, I think I maybe tried to but I have no idea. And when she came back again I really had very little idea of what she was thinking. And we rely on feedback, of course we do, to let us know if we're doing OK." (GP2)

Impact of inductive reasoning

When an inductive mode of reasoning is foremost, the facts of the case are used by the doctor in conjunction with other information to configure both diagnostic and therapeutic decisions. This mode of reasoning is more likely to produce diagnostic confidence and lead to perceptions that therapeutic action within the consultation is meaningful

a) Diagnostic confidence

This doctor is discussing the process through which she concluded her patient was not depressed. This was not based on an objective evaluation of her symptoms but on trust in her personal experience of the patient.

“I was satisfied that she wasn’t depressed this time because she would have told me. She’s quite happy to come out with that kind of thing because she recognises it in herself quite promptly. So I felt I didn’t need to dig for anything. If she says she wants her (oral contraceptive) pills, she probably just wanted her pills.” (GP3)

Here, rather than interpreting the facts of the case, as would happen if deductive reasoning was employed, the doctor uses the insights and knowledge she has from her experiences with the patient in relation to other problems to reach a tacit understanding of her current situation. As Atkinson¹²⁵ suggests personal knowledge and experience are not normally treated by practitioners as reflections of uncertainty but as warrants for certainty. In other words the perception the doctor has that she knows the patient (rather than knowing about her case) is knowledge she can rely on to make diagnostic decisions.

b) Meaningful therapeutic action

When an inductive mode of reasoning is pre-eminent with an individual patient, the facts the doctor knows about the patient are understood within the context of the patient’s life making meaningful therapeutic action possible. Meaningful therapeutic action is critical if doctors are to experience consultations as maximally satisfying. Here, an interpretation of factual knowledge within the patient’s world permits the doctor to act in partnership with the patient to individualise the therapeutic intervention.

“Even with a fellow like that who had, certainly had a depressive illness and he’s probably passed that now, his major problems lie in his confidence about his own self and finding a direction. He’s going through a kind of midlife crisis, because he’s this age, he’s single, he’s wanted a wife, he’s wanted children, and he feels he’s well passed all of that stuff now. So you’re trying to find ways of him coping with that bit of life that he’s in at the moment, which aren’t hard psychology- behavioural cognitive stuff- but neither are they about taking tablets and this will make you better. So it’s trying to find ways that suit him as an individual to get better.” (GP11)

Here there is evidence of complex, shifting local definitions of knowledge, thought and action. Knowing the patient supplants technical medical knowledge as the basis for therapeutic thought and action. In contrast when deductive reasoning was paramount knowledge of the patient was insufficient to generate alternative ways of proceeding to resolve the patient's problems.

c) Outcome and patient response

Furthermore when inductive reasoning is applied the consequences of the consultation in the patient's world become easier to predict and this insight contributes to the doctor's positive feelings about the consultation.

"The other thing that made me feel good about that consultation was the fact that I knew this guy was feeling good himself, and I knew that he was going out feeling that he trusted me, that he had a good doctor who was doing as much as he could for him and he was getting everything he would expect from a GP and I knew that having been to see me would have had a good effect on him and that he would go home thinking 'Right I feel happier'." (GP1)

The doctor's own subjectivity is clearly highlighted in consultations with patients in whom inductive reasoning is paramount. The doctor's action may deviate from what might be expected after an objective appraisal of the facts of the case and based on information from diagnostic technologies. Their interactions with the patient and experiences allow them to exercise discretion about what should be done or not done. This doctor is concerned that an objective appraisal of the facts of this patient's case might conflict with the assessment made by his partner who knows the patient. Therefore he restricts his actions to the technical (paper function).

“I think you know when you become involved just for a sick line with someone in whom you haven’t been involved all the way along, you’re reluctant to say strip off, let’s examine you and see how you are because you might then provide him with another opinion which is conflicting to what he’s had. So I tend to shuffle those on, on the basis that he’ll be seeing (a partner) – presumably he couldn’t get an appointment with (partner) that day. So unsatisfying in a sense that you know you’re just fulfilling a paper function.” (GP7)

Conversely, here the doctor claims a particular licence for his actions based on the authority of his personal knowledge rather than the authority of biomedical science (the right thing). This highlights that general practitioners’ clinical decision making is not a disinterested, impartial process but one which is susceptible to shaping by social influences.

“I think despite the fact that we might not have done the *right* thing with her, I don’t know that that probably mattered all that much because she’s the type of patient....if they like you it makes you feel better and I think she probably likes me and I know she appreciates what I do and respects me.” (GP10)

Mutual trust

The knowledge a doctor has of a patient is constructed by them in interaction with the patient. This knowledge serves certain purposes for the doctor beyond the confines of individual consultations. The foregoing quotation hints at the feeling that patients who are known by doctors have a sense of commitment to that doctor and that this translates into “an attitudinal contract between doctor and patient”¹⁸² based on respect and mutual trust. This so called contract might be useful for the doctor in protecting him from the vicissitudes of modern medical practice, in particular litigation.

Coming to know a patient inductively is more likely to result in an inter-subjective construction of the patient, and in turn is more likely to result in a shared

interpretation of the patient, their problems and the nature of the doctor-patient relationship. This shared interpretation predicates mutual trust. Knowledge of the patient gained deductively is more likely to be open to contest by the patient. For example this doctor had interpreted information about the patient in such a way as to construct him as someone whose health was being undermined by domestic stress and pressure. The patient did not deny that such stresses existed but rather their relevance to his current health problem. In other words he did not share the doctor's interpretation of him or his problems and chose to openly contest it in the consultation.

"I don't know the problem. It was because he had seen me about a year ago a few times. His dad's an alcoholic and he'd had a really bad time. He lives with his mum and dad and his father is just terribly dysfunctional and difficult and he'd had a particularly bad spell and been very stressed and been off work.....He was still not satisfied with his skin and my problem is that looking at his skin it certainly wouldn't warrant roaccutane, I mean it wasn't that bad and it's more obviously I think more of a psychological thing....And every time I tried to get into the psychological thing he just blocked it....We weren't getting into that." (GP5)

In this situation the patient has paralysed the doctor by resisting her interpretation of him. In effect he has denied her knowledge of him and rendered it unusable. He has also to some extent denied the legitimacy of the extended medical gaze. As Armstrong has pointed out the main change in the focus of the clinical gaze in the 20th century has been to extend the right of surveillance beyond the bodily to the psychosocial and to see the details of a person's relationships as the site of ill health¹⁸³. This extension however requires the implicit consent of the patient and in this instance this was not forthcoming. Consultations in which such consent was denied were usually problematic and dissatisfying.

Deductive and inductive knowledge are not mutually exclusive. Doctors are able to have, and often do have, both types of knowledge about patients, and indeed each type of knowledge can complement the other.

That patients implicitly consent to interpretations of them suggests that they exert more control than the foregoing analysis has perhaps suggested in determining how they are known or come to be known by their doctors. Indeed from doctors' accounts it is clear that they are aware of consultations in which the patient has actively resisted attempts to get to know them, or at least has delineated definite parameters within which they are willing to be known. Respondents were able to identify patients who were easier to get to know.

"Sometimes it is extremely easy, you know, some patients are very good at getting a rapport going." (GP14)

And others who were not, as these doctors say of different patients:

He doesn't give a lot away, it's a bit like getting blood out of a stone." (GP8)

and;

"She doesn't sort of give you very much reaction to anything. She's not depressed that's just, I guess, how she is. She's a very sort of dead pan face and you're not quite sure why that is whether it's that she's one of the people that isn't as confident seeing a doctor as many of our patients are or whether it's that there is some underlying psychological problem. I don't think there is really I think that's probably just her." (GP5)

Therefore the way in which doctors come to know patients and the reasoning that is applied in different consultations is not always intentional. When patients refuse to open up to scrutiny in the way doctors would like doctors feel compelled to employ tactics designed to encourage the patient to open up more of their self to the doctor. However in doing so by default they adopt a form of deductive reasoning and invite the concomitant disadvantages.

"I find with elderly people if you can find out about their family and start asking about their grandchildren and things like that when you see them it sort of switches them away from their complaining mode into a more appreciative happier outlook. And it's a question of finding little levers that you can use." (GP8)

The way in which doctors understand a patient is instrumental in their evaluation of the moral status of the patient. The patient is often legitimised through this process and the doctor comes to see them as having valid and authentic claims on their time and on other services. For example this doctor says,

"If you go through the catalogue of her life you know where she's coming from and it all makes sense when you see what's happened to her. But if you saw her as a one off you'd think she was a very mentally dull poor soul. But I think you have a rare insight into somebody's life and I completely understand why this lady's how she is. She's been to see somebody at the pain clinic nine times, nine separate referrals in the last 15 years for pain because she has a lot to gain by being ill." (GP2)

This moral judgement seems to be an important factor in the calculation the doctor makes about the effort involved in working with a patient and the potential reward.

"I'm very controlled about that....I must make some judgements about the extent to which I think these people are helpable or actually want to change in some meaningful way, if they do I'll work with them, if they don't I'll freeze them out, probably politely but nevertheless freeze them out." (GP15)

Consequences of knowing the patient for the doctor.

Most commonly the sensation of knowing a patient impacted positively upon doctors' affective responses to the consultation. Doctors usually felt a sense of responsibility to those patients whom they felt they knew. The responsibilities felt most keenly were to co-ordinate their care across health and social sectors, to advocate for their health and care and to protect them from inappropriate

intervention. This responsibility was usually welcomed and in most cases engendered an enhanced sense of closeness in the doctor-patient relationship which was valued, and contributed to satisfying experiences for the doctor in consultations.

However this closeness is also very demanding of doctors and in some circumstances becomes a burden rather than an asset. For example this doctor talks about how he feels "stuck" with a patient whose health has deteriorated over the last few years with bowel cancer and ischaemic heart disease.

"I think that I'm stuck with her. I mean she's a lovely lady but I know and she's talked about it before that she's worried about cancer and so I think there will always be that cloud sinking over any consultation she and I have. We get on very well and she always comes to see me. I think I know her agenda and I think she knows that I know that she's worried about that.....I don't say I look forward to seeing her name on my surgery list but I accept that she's someone who lives on her own, she's been healthy and then suddenly in the last two or three years major things have happened and she feels a bit uncertain, and I think her self esteem and self confidence have taken a knock. Part of our role has to be to see her and support her." (GP7)

In situations where doctors felt closeness with a patient to be onerous, consultations were rarely satisfying. Doctors also recognise that closeness can bring with it a sense of obligation beyond responsibility and that this can afford a coercive element to a relationship that is unwelcome.

"There has to be a bit of distance I think. Although there are some people that that's lost (with) and ideally I wouldn't want that. It's quite nice to have a few patients like that but you wouldn't want a lot. I suppose the danger is the longer you stay in a practice you might get more and more like that. They all make their demands and you can't say no to them when they give you a bottle of wine at Christmas." (GP8)

Conclusion: relationship between knowing and continuity.

The concept of knowing a patient is clearly important in the way general practitioners attribute meaning in their work and is central to their feelings of satisfaction. It is also potentially important conceptually because of how it might relate to the issue of continuity of care, an expressed core value of general practice. The literature about continuity of care tends to conflate this concept with the notion of doctors knowing their patients. The relationship however is unlikely to be a straightforward one especially as more than one definition of continuity of care exists. The structural arrangements of general practice which encourage longitudinal continuity – that is care from one doctor spanning an extended period of time and more than one episode of illness- are assumed to underpin doctors knowing their patients. Longitudinal continuity implies a personal relationship between doctor and patient and is the basis of personal continuity. Personal continuity implies doctors have a sense personal of responsibility for patients, and provides the context for the delivery of care which takes account of the patient's personal and social circumstances.

The findings presented in this chapter suggest that the concept of knowing is in fact contingent upon the reasoning of doctors about patients within the consultation rather than the structural arrangements for service delivery. Furthermore such reasoning in relation to an individual patient is not the exclusive preserve of a single doctor but depends upon the nature of the interactions between a doctor and a patient in individual consultations. Therefore different structural arrangements should not inevitably put an end to the opportunity for doctors to know their patients as person. However arrangements that undermine existing beliefs about the nature of the doctor-patient relationship in general medical practice may do so.

Summary

To summarise, a sense of knowing the patient emerged as a crucial factor in determining doctors' experiences of consultations. In terms of understanding these experiences, a distinction was drawn in this chapter between the doctor knowing the patient-as-person and having knowledge about the patient. These alternative interpretations of knowing are seen to be contingent upon the way in which the doctors reason about patients in their consultations. Knowing the patient-as-person was conditional upon the doctor exploring the patient's subjectivity by means of an inductive mode of reasoning, whereas knowledge about the patient could be derived from a deductive mode of reasoning. The different modes of reasoning underpin alternative interpretations of the patient in the consultation- either as a case or as a social actor- and these interpretations influence the subsequent course of the interaction. Doctors' actions in the consultation in respect of diagnosis and management are shaped by the way in which the doctor knows the patient, and a sense of knowing the patient appears to assuage the clinical uncertainty endemic in medical practice. Moreover knowing the patient tends to allay much of the uncertainty the doctor may have about the patient's subjectivity.

Furthermore a sense of knowing a patient-as-person facilitates meaningful therapeutic action within the consultation which seems to be important in many of the consultations ascribed most satisfying by doctors. However not all consultations in which the doctor described a sense of knowing the patient as person were among their most satisfying. At a mundane level, doctors tend to have relatively stable expectations about patients' behaviour in consultations, as I demonstrated in chapter 5, and at an elevated level, this involves the attribution of (and consent to) particular social identities. This attribution of social identity to patients is crucial to doctors' and probably patients' experience of consultations. In

the next chapter I will go on to explore how attribution of (and consent to) a particular social identity for themselves is also decisive in configuring doctors' experience.

CHAPTER 7: FINDINGS – KNOWING THE SELF

Introduction

In the previous three chapters I have described and discussed how practitioners' experiences of consultations are influenced by their knowledge of the patient, their evaluation of the patient in light of this knowledge, and their assessment of their own performance within the consultation.

I have suggested that a doctor's assessment of his or her own performance is based upon an implicit understanding of what is a good doctor. This assessment is a normatively referenced process in which the self-evaluation is made against criteria whose origins can be clearly traced in the professional discourse about best practice. In this chapter I will go on to examine what doctors know about themselves, how they develop this knowledge and investigate how this relates to their experience of consultations.

I contended in an earlier chapter that the idea that the doctor must in some way know the patient is deeply embedded in the discourse about general practice. The notion that the doctor must in some way understand himself is less prevalent and for a long time the doctor's subjectivity was neglected in work about general practice¹⁸⁴ in favour of the patient's subjectivity. However lack of emphasis on doctors' self-knowledge does not necessarily mean that this is postulated to be unimportant but rather that it is assumed in a discipline which routinely conflates the personal with the professional through the therapeutic deployment of the doctor.

Self-knowledge and understanding are very closely allied to a sense of self-identity or social identity. And, to quote Jenkins¹⁸⁵ “‘identity’ has become one of the unifying frameworks for intellectual debate in the 1990’s”.^{xix} At the heart of this debate seems to be the nature of the relationship between individuals and society. Before proceeding to the crux of this chapter, it is necessary therefore to consider very briefly the ways in which social identity has been conceptualised.

Identity and the relationship between individuals and society

Accepting the basic premise that social identity is an understanding of who we are and who we are not, various theories of social identity have been put forward that are underpinned by different versions of the relationship between the individual and society¹⁸⁶. Theories range from those concentrating on societal processes as the primary force in producing identity to others focussing on the nature of the self and the mind. The key questions seem to be: do individuals have an existence separate from the society they inhabit? Or do societies have an existence distinct from the individuals that comprise them? In other words the debate is about the extent to which individuals are either constrained in their actions by the society in which they live or alternatively able to determine the course of their actions within society. This axiomatic distinction between individuals and society is mirrored in the debate about the qualitative differences between collective identity and individual identity.

^{xix} Discourse about identity is evident in the writings of sociologists, psychologists, anthropologists, historians and many more. Each group approaches the subject of identity from a distinct philosophical standpoint. Indeed the multitude of prefixes to “identity” used by authors: social, self, personal, individual, collective, cultural reflects these differing views. It is not my intention to enter into this debate about the nature of identity rather to relate the concept empirically to the data.

At its most straightforward collective social identity is seen to originate from recognition of commonality of behaviour and circumstances between members of a group, and of difference from others. It relates first and foremost to a sense of belonging to a particular grouping. Conversely individual identity is considered to originate from recognition of what is unique about the self, rather than what is shared with others.

Jenkins however argues against there being such a clear distinction between collective and individual identities. He contends that the individually unique and the collectively shared are routinely related because the processes by which they are produced, reproduced and changed are analogous and both intrinsically social¹⁸⁵. For him social identity can be defined as the way in which individuals and collectivities are distinguished in their social relations with other individuals and collectivities. It is the systematic establishment and signification of relationships of similarity and difference, and the understanding of who we are and of who other people are. Hence the way in which a doctor or indeed any individual understands himself or herself is not necessarily different from his or her understanding of others. Indeed the two may well be intimately related. Therefore in the way I have suggested that doctors come to know patients through different patterns of reasoning within the consultation, I also suggest that knowledge about themselves as doctors derives from their interpretation of the experience of consultations. That is, what they know about themselves is much more than an organisation of biographical facts, it is constructed through the multitudinous interactions that constitute their working life. Importantly what general practitioners develop is experiential knowledge about themselves which is as central to the accomplishment of their everyday work as abstract theoretical knowledge about what constitutes general medical practice.

Doctors' social identity

Giddens has suggested that we do not have a unitary identity but are a collection of identities brought into play by social action¹⁸⁷. Doctors' professional identity is therefore brought into play by their actions in the wider conduct of their work. In general the professional (social) identities doctors consent to can be considered as having two components: a collective component and an individual component.

The collective component of doctors' self-identity derives from their experience of themselves as technically proficient actors in the clinical arena and also from their experience of membership of the group of doctors and general practitioners. Clinical identity is particularly important in the conception of self among general practitioners and reflects their ability to carry out effectively the technical tasks demanded in their role as doctor. This relates to their membership of the medical profession as a whole, as much as to their membership of the group of general practitioners, and relates to them behaving in a way that is recognisable and shared by other doctors. Over and above this during the last 30 to 40 years general practice has generated pervasive forms of discourse about for example holism, whole person medicine, communication and patient-centredness. These discourses have provided a framework for a collective professional identity for general practitioners that is also important in defining general practitioners' concepts of themselves. Collective identity is the component of general practitioners' self-identity that is engaged most obviously in the type of evaluation of performance I described in chapter 4.

The individual component of their identity relates to their uniqueness as a doctor, and to their knowledge of themselves "as person" in the context of their role as doctor. This realisation is often founded on factual and biographical knowledge resulting from formative working and sometimes personal experiences.

However in the context of working as a general practitioner, where there is a history of the doctor deploying himself or herself therapeutically, the distinction between collective and individual components is often obscured. In other words the “therapeutic power” of the doctor is a product of both his collective and individual identities. Furthermore as Jenkins suggests the social processes by which the collective and individual components of doctors’ identities are produced, reproduced and changed are comparable¹⁸⁵. In this chapter the consultation is explored as a social process that potentially constructs doctors’ self-identity.

In doctors’ accounts of the subjective experience of consultations they did not always talk explicitly about their knowledge and understanding of themselves. However a ‘sense of self’ was deeply embedded in doctors’ accounts of their experience of consultations. This sense of self seemed to incorporate their social roles and responsibilities as doctors and general practitioners whilst at the same time being unique. In other words collective and individual components of their social identity were instrumental in doctors’ accounts.

In the rest of this chapter I will explore the way the self-understanding which configures the identity doctors take into consultations is revealed in doctors’ accounts. I will go on to investigate how a doctor’s self-identity might shape their expectations of themselves in the encounter and explain their motivations. I will then examine how the experience of the consultation and reflection upon it impacts upon, maintains, modifies or challenges self-identity. Finally I will explore the relationship between self-identity and the emotive response to consultations.

Self understanding and identity

Giddens¹⁸⁷ suggests that self-identity is “the self as reflexively understood by the individual in terms of his or her biography” He also suggests that the process by which this understanding is reached is one which involves reflexive ordering of self-narrative. Self-identity is derived from a chronicle of personal past experiences, which are interpreted by the individual and integrated into a changing personal biography in such a way as to maintain coherence. Jenkins proposes a definition of self as “each individual’s reflexive sense of her or his own particular identity constituted vis a vis others in terms of similarity and difference”¹⁸⁵. In their accounts doctors seemed to understand themselves both in terms of a unique self-biography and in relation to significant others.

For example this doctor describes the biographical elements which led to her choice of general practice as a career. She orders the experiences she has had and interprets her reflections upon them in a way that makes sense of her decision to embark on a career in general practice. Thus she constructs a consistent reality of herself as a general practitioner.

“My mum and dad were GPs so I knew all about it and I don’t think it was just boring. I kept trying, to think of other things I wanted to do but I never could, nothing else ever appealed. And they did actually try quite hard when I was teenager to push me away from medicine because they were worried I would just drift into it because they were doing it but you know I saw what they were doing and I thought it looked good and I didn’t want to work in an office and I didn’t want to be an academic and never came up with anything else....I went through all the specialities thinking I wonder if this is going to change my mind and I did quite like paediatrics and I quite liked obstetrics but neither of them enough to make me want to do that all the time.” (GP8)

Prior to embarking upon a career as a general practitioner doctors have almost invariably experienced work in other sectors of the health care system in the UK

and in some instances in other health care systems elsewhere in the world. Through these past experiences doctors come to know more of who they are in a professional sense, not only through building up a stock of technical clinical expertise but also and perhaps more saliently by reflection upon the experiences and their meaning to them individually. They order the experiences so that they have a trajectory that is coherent in terms of events that follow.

For example this doctor integrates the various phases of his career into a coherent narrative which illuminates his present position

"I did a round about vocational training scheme and did some obs and gynae and liked it for a while and did the MRCOG in that because I'd done lots of work for that, and then completed vocational training to be a GP, so sort of halted in the middle of it.

Int: So had you always had GP as a goal?

Yes, I think so, probably yes. But I enjoyed the emergency element of obs and gynae for a while, I just wanted to try it out but discovered I didn't want to do it after all...I was interested in doing general practice anyway. I think that was where I wanted to go. I think it suited me when I wasn't married and didn't have other commitments which really mattered to do something else for a short time anyway. So it was useful at that time to have experience in something else and that's why I did it. And then commitments and family and a more settled existence that probably had quite a lot to do with it as well." (GP10)

This account reveals how self-identity is not just something given but is created routinely by individuals in reflexive activities. This single-handed doctor also defines his concept of himself reflexively, but less in relation to his biography and more in relation to others with whom he perceives similarity and who as a group implicitly differ from people working in larger groupings.

"I do value not being part of a group both for administrative and whatever you call it psychological reasons.

Int: Why is that?

I suppose the difficulty I have getting on with other people and my refusal to accept that any other diagnoses or way of doing medicine is any good except mine (laughs). Rigid, inflexible, intolerant I suppose are the attributes of a single handed doctor." (GP9)

Collective identity: the production of similarity and difference

The sense of belonging to a group is an important aspect of doctors' self-identity. In their accounts general practitioners defined their collective identity through reference to difference from a variety of others. Others included the lay person, other primary care health professionals and other doctors. Here this doctor defines the identity of general practitioners by delineating differences in behaviour and circumstances compared to others (best friend and bank manager).

"You wouldn't tell your best friend that you were impotent, but you have to be the sort of person that a patient will tell that they are impotent. So you can't be their best friend you have to be something completely different. But at the same time you can't be a bank manager, you can't be an aloof guy in a tie who is very formal. You have to be, it's something different and it's that relationship. I mean that's what being a GP is all about: being the person that when someone says 'I'm impotent and I'm worried about it and I don't want to go and see somebody and talk about it', I'm the guy that they do that with." (GP16)

So in asserting their collective identity general practitioners distinguish themselves from non-members of their group. Self categorisation theorists¹⁸⁸ suggest that we not only act as members of groups but actively bring that group into being by adopting strategies that highlight differences between our group and other categories. Differentiation involves the creation of boundaries outwith which everything else does not belong. In certain instances where differences are clear cut these boundaries are relatively easy to create, in other circumstances differentiation is trickier and involves more vigorous work to fashion boundaries.

This action can be seen clearly in the way respondents talked about themselves in contrast to hospital doctors. The work involved in defining the “clear blue water” between hospital based doctors and general practitioners was greater than that involved in differentiating themselves from lay people. After all the initial socialisation processes are the same for all doctors⁹². The areas in which respondents most frequently drew distinctions between hospital doctors and themselves included the form and function of the consultations they were routinely involved in, the nature of the relationships they had with patients and the overall content of the work.

Form and function of their consultations

The part of the consultation in shaping the collective identity of general practitioners has been fostered by the work of the Royal College of General Practitioners. The primacy of the consultation in general medical work is underlined by its prominence in many of the publications of the college and by its centrality in the process by which doctors gain membership of the college. In terms of the function of the consultation as a validation of collective identity, this doctor's views were typical.

“I think that's just something that as you do more general practice you get less and less worried about making a diagnosis, and become more and more aware that each consultation is a piece of the jigsaw and that these people will come back. That family in the first consultation (I've seen) many times since the girls were born. In fact I looked after the mother ante-natally so you have an ongoing thing which is one of the good features of general practice I think. I tend to see consultations as a step along the way rather than an event in its own right. And I think that's, with the trainees and things, that's one of the things you try to get over because they've come out of hospital posts where everyone has to be pigeon holed, and getting around to the way of thinking that this is in fact an ongoing thing and you don't have to deal with everything at one consultation.”
(GP7)

And this doctor alludes to differences in the form of the consultation in different settings.

“I suppose I’d done four hospital jobs and in all of them I’d become disillusioned within about four months of doing it-robotic and feeling that there wasn’t that much there, that much more for me to get interested in. That didn’t happen in general practice.....There was more to it. I got quite interested in the consultation process.....and there was a lot more to that than there appeared to be in the hospital consultation process.” (GP11).

Hence the function and form of the consultation as a device in producing the collective identity of general practitioners is evident. Furthermore the endorsement of this strategy has depended upon the evolution of a professional body, the Royal College of General Practitioners, to advocate for these defining features. Thus general practitioners have actively brought the category “general practitioners” into being through actions which have help create a boundary that separates them from hospital based doctors.

Relationship with patients

The nature of the relationship they enjoyed with patients was also signalled as distinctive by interviewees. This was differentiated from doctor-patient relationships in other settings by virtue of typifications such as continuity, cradle to grave care and a focus on communication.

"I think the biggest plus (of general practice) is the continuity and to be able to follow the course of something all the way through. And also to see somebody living his or her life. So you know to see somebody as a young person and then watch them having children, and watch the children getting older and things like that, I really like that because it makes you feel involved with people. And I think the other thing I really like about it is the variety and unpredictability of it. You just don't know what's going to walk through the door next. And I think I get bored very easily so I think general practice is one way of avoiding that because it's always changing." (GP8)

and,

"I always saw general practice as being very very different from other forms of medicine because of the communication and because of the length of the relationship you can build up with patients. And that's what attracted me to it." (GP1)

Furthermore these typifications are also used reflexively to explain individuals' choice of general practice as a career which is important if doctors are to build a rewarding sense of identity. This makes clear that self-identity is to a large extent what we make of ourselves rather than what we are, and as such depends on re-constructive endeavours.

"It was a positive decision it was going to be general practice unless I could think of something better. And the reason was I thought I was the kind of person that was good at communication, would be good at building up relationships with people." (GP1)

Overall content of work

Further examples of re-constructive endeavour can be seen in doctors' accounts of their rejection of specialist careers.

"I went into my training sort of thinking well if anything particularly grabs me I would want to specialise. I was interested in obs and gynae ,I was interested in psychiatry but I felt to do it all the time I don't think I would find that interesting but I think you get enough of each speciality -I liked paediatrics as well-in general practice, so it's ideal." (GP3)

Such preference for generalism over specialism was alluded to by general practitioners as another way in which they were different from hospital specialists.

Doctors also occasionally felt a need to distinguish themselves from other professionals working in primary care settings in particular nurse practitioners.

"A well trained nurse practitioner can manage most physical disease, particularly chronic things like diabetes. But I think dealing with somebody with a physical manifestation of inner turmoil is something only a GP can do." (GP16)

Individual identity: unique characteristics

In their accounts the respondents also talked either explicitly or implicitly about themselves as doctors. They talked about their strengths and weaknesses as doctors, about their preferred style of practice, and their philosophy. Mostly they privileged some aspects of being a general practitioner above others and in so doing created their own identity. For example this doctor saw himself primarily as a medical communicator, a conduit for knowledge and expertise. Here he is talking about a consultation in which he had been able to help a patient understand the link between psyche and body in producing his symptoms.

"The meat of it was that he was someone presenting a series of physical symptoms and wanting to make sense of how they came about. I always find those very satisfying, I like doing that.... It can be quite a difficult job sometimes making the connection between a real physical symptom like a cramp, gut ache and stress can be quite hard. I mean there are lots of cultural things like if you're saying it's stress then they are imagining it and you've got to overcome that and help them understand how the way they feel can produce quite real measurable physical symptoms. He then started asking all sorts of questions like "how's that connected with him having to get up for a pee all the time" and he was able to draw all those together for him. I think it is my strength particularly that kind of consultation." (GP16)

Whereas this doctor saw herself more as a medical problem solver.

"I like the medical model, I think I do think along medical lines and I have to think more laterally to try to do any good on the sort of social or psychological things. I find that much more difficult, it doesn't come naturally and so that sometimes is a bit more tricky. I find it (medical) easier to do, it comes quite easily to me." (GP2)

The personal traits that doctors allude to in their accounts are used to differentiate themselves from the generality of general practitioners. This is essentially a private process that creates *for them* their individuality. This individuality might not always be apparent to others.

"I felt I was the right sort of person to be seeing this woman and I was more likely to be able to get somewhere with her than certainly any of my colleagues.

Int :Why did you feel you were the right sort of person?

Partly my experience both in medicine and previously as a social worker that I feel very comfortable with the messy sort of psychosocial problems. I've got a very large amount of experience of them and a lot of different angles I can sort of employ" (GP15)

This doctor intimates that his self-identity is decisive in configuring expectations of himself in the consultation. I will return to this issue of doctors' expectations of themselves later in this chapter.

Self-identity is not immutable but changes over time. As doctors progress through their general practice career they reflect back on their experiences and recognise how they have integrated these into their self-conception. The process of change is interpreted reflexively in such a way as to maintain the coherence of their self-biography. For example this doctor reflects on a consultation in which there was some degree of therapeutic uncertainty and how he feels about the consultation highlights a change in his identity over time.

"I'm quite happy about it (making decisions about treatment in situations of uncertainty) really. I think probably when I was younger I used to fret about that and wonder gosh am I doing the right thing, am I going to harm someone but I'm quite happy now to make the decision, I don't prevaricate about it." (GP7)

The emphasis earlier in his career was on protecting the clinical aspects of his identity as a doctor. He relates being concerned to do the 'right thing' in respect of instituting treatment. Thus his technical competence is highlighted. Now he defines himself less in terms of the clinical identity dominant in collective identity and more in terms of individual identity. Speculatively one could suggest that this modification of his thoughts and actions has resulted from interactions in the intervening period.

So each doctor takes into the consultation an individual self-identity. This is not unchanging but is dynamic and constructed through their social relationships. Hence this a priori self-knowledge is not just recollection of biographical events but is put together by doctors through reflection and retrospection on these events. This reflective process informs the development of an individual philosophy of practice. This self-identity is then taken into the individual doctor-patient encounter and configures doctors' expectations of themselves during the

consultation and explains their motivations within the encounter. It is also crucial to their satisfaction in encounters.

Identity and expectations

Doctors have expectations of themselves in consultations. Some of these are related to issues of best practice as described in chapter four, and are entwined with their professional identity as clinicians. Others are related to their perception of themselves as a doctor, and the way in which they differentiate themselves from the collectivity of general practitioners.

The perception that an aspect of practice is a particular strength serves to set doctors apart, at least to some extent, from some of their peers. It also leads doctors to have specific expectations of themselves in consultations. These expectations relate to what they might reasonably expect to achieve in the consultation and how they might do that. For example this doctor regards herself as particularly adept at helping patients with emotional problems, and differentiates herself from other doctors who she ascribes, through repeating the sentiments of patients, as hopeless. However she has clear ideas about the constraints upon success in these circumstances.

"I see plenty of them with their stresses, I'm not that fond of them just appearing as an extra and bursting into tears, because you just know you can't really achieve much without a wee bit of time. It's interesting you see patients and sometimes they'll tell you about having seen someone else and they didn't think they understood or they didn't listen and they were hopeless and they never came back to the doctor. I think I'm aware that (it's important) how you speak to people when they come in like that. They're pretty fragile ...and it's a bit of a balance really between giving them some hope and encouragement and talking through where they're at and help them to see themselves." (GP12)

The articulation of constraints serves to modify her expectations within the consultation and to protect her perceived individual aptitude.

Expectations are also configured by a self-awareness of perceived limitations. Again these can be technical weaknesses that expose frailty within their identity as competent clinicians. Doctors recognise areas of clinical practice about which they feel less confident, and are apprehensive about consultations in these areas. This doctor has a longstanding sense of inadequacy when dealing with children's problems. His objective assessment that he lacks technical expertise in this clinical area has been rationalised and results in a subjective feeling of unease.

"I feel more uneasy with paediatrics that I feel with anything else. Basically because I didn't have any training in paediatrics. I suppose I've had plenty of experience with children but that's the one set of people I feel uneasy about." (GP10)

This doctor also reveals an uncertainty, in her case in relation to the natural history and management of heart disease.

"I think just by nature of being a female GP I don't see a lot of cardiology so really I'm not that certain what to expect." (GP3)

More commonly however respondents recognised interpersonal situations which they find difficult to deal with. As they get to know their patients better they have expectations about consultations with certain patients predicated upon their knowledge of themselves. This doctor is reflecting upon an unsatisfactory consultation with a mother and her baby.

"I think I'm not as tolerant as I used to be. I think what it is, is that I want them to talk to me and communicate but so often they'll come in and bang there's the baby and they don't say anything, they don't have any conversation. It's as if I am a foreigner to them and you know they can't even pass the time of day. They're so 'oh he's got a temperature, do you think it's meningitis or something' you know and that's it. And it makes me feel very vulnerable. It's not the child that gets me, it's the anxiety, that's what gets me." (GP14)

Reflections on interactions usually either reveal reconciliation to personal weaknesses or a desire to modify characteristics when an opportunity arises to do so.

Thus doctors' self-attributed identity is decisive in mediating the expectations doctors have of themselves within consultations. Being successful, as I described in chapter 4, is important in doctors' evaluations of their performance within consultations. However their self-identity determines the situations in which they anticipate success. Expectations being met or surpassed are implicated in doctors' positive emotive responses to consultations, expectations of themselves not being met influence negative responses to consultations. I will return to doctors' emotive response to consultations again later in this chapter.

Identity and motivations and values

Something about doctors' self-identity is also revealed in the way in which they talk about or allude to their motivations in consultations. Their motivations are wider than their expectations of individual consultations. They reflect their underlying approach to their work and the overarching values upon which this approach is founded.

Values are generalised and relatively abstract, and a value system is a generalised knowledge structure or framework that guides evaluations of what is good or bad,

desirable or undesirable in particular circumstances¹⁸⁹. In the specific situation of general practitioners' work, a doctor's personal set of values will determine which actions within the consultation and which eventualities, in terms of patient health related behaviour, are most desirable.

The world of primary care and general practice exists because there are fundamental values that are taken for granted by practitioners and patients alike. Inevitably therefore the motivations of professionals working within primary care are broadly similar. This study was not designed to investigate the values of general practitioners. However a second order analysis of the data does provide some evidence about practitioners' sets of work values. Actions in, and the conduct of, consultations will be deemed desirable not only because they meet evaluative standards but also because of their integrity with individual work values. Work values can be seen to underpin evaluative frameworks that define desirable outcomes and ways to achieve them. For example evaluative frameworks that emphasise the importance of clinical effectiveness or patient-centredness are underpinned by a work value that might be described as concern for people.

Values are also relative. That is they can be defined in terms of preference for one sort of behaviour over its converse. Here this general practitioner is describing one of the guiding principles by which he practices in terms of an inclination for one type of therapeutic activity over another.

"I think I am probably a lifestyle suggester rather than a therapeutic pill pusher. I'll try and get people to improve by non-pharmacological means, if you see what I mean. I suppose I'm aware of precedent setting when you put people onto medication then they're likely to think they need to keep coming back." (GP7)

In doing so he hints at another motivation in his work, the desire for patients to learn to manage their own health and illness, rather than rely on health professionals. This was a relatively common value espoused by doctors. For example:

"I think I am a source of information for people. I'm not there to tell them what to do but it is my job to try and inform them of what their behaviour might mean to them in fairly neutral terms." (GP2)

Nevertheless, this value encapsulating the extent to which the doctor believes the patient has the responsibility for their health emerged in the data as one area where difference between doctors existed and was deemed tolerable. Some doctors held an underlying belief that they were ultimately responsible for the patient's health. As this doctor says, in outlining his positive attributes as a general practitioner.

"A continuing personal responsibility for patients and the realisation that the buck stops here." (GP9)

Whereas, in contrast, this doctor hints that the buck stops with the patient.

"I'm quite happy to make empirical diagnoses, I'm quite happy to let people go out of the door without diagnosis signed and sealed or even necessarily to have a nice medical word for what's wrong with them. So as long as I feel I'm getting somewhere with it or that we've covered the possibilities in terms of danger and such. You know the responsibility for that individual's health doesn't really lie entirely with me, it lies with me while their coming here and giving me their problem. This is how I feel about it. I organise their problem for them to a certain extent, put in a bit of safety work and then off they go but they've still got their problem. They take it away with them, and particularly if there's other things to do about it, beyond things like referral and stuff then it's very important for me to make sure that the patient understands that it's up to them to bring that back or to contact me. It's very much their problem, they've come to me in the first place, they'll do it again." (GP10)

Personal value systems are also constructed by the relative importance of any given value over others in the system. Again in this area the data hints at differences between practitioners. An individual's personal set of values guides their experience and gives meaning to their work experiences. For example a number of doctors emphasised the importance they attach to being able to work independently. This was not a reflection of their employment status but of the value they attach to the intellectual challenge of diagnosing and managing a patient's illness and to the importance they ascribe to the freedom to be able to do so. This doctor exemplifies this value in discussing a maximally satisfying consultation.

"I was able to administer treatment, perform appropriate investigations, interpret them and they came back and I reviewed them and they were better and I did all that independently without the need to resort to anybody else's opinion or input." (GP2)

The values held by doctors impinge upon their motivations within consultations. Motivations are the sources of desired action, but in the context of the practical exigencies of everyday work they are not always the reason for action. This disparity opens up further potential for doctors to experience dissatisfaction with consultations.

Constructing, maintaining, modifying and challenging identity.

Consultations can be seen as events which individuals need to integrate into their self-narrative. Failure to do this risks discontinuity in their narrative, fracturing of their self-identity, and dissatisfying experiences. What is happening or what has happened in everyday consultations is subject to interrogation by doctors to

determine its fit with their a priori identity. The data generated in the interviews in this study can be seen either as a reflection of this process or alternatively as constitutive of this reflexive process.

Maintaining identity

During and following consultations doctors seem to maintain their identity through a process of validation. This is a continuous iterative process which is undertaken by the doctor himself but requires ongoing interaction with others, in particular patients. Patients therefore serve a validating function for the doctor. In the simplest sense the mere presence of a patient in a consultation validates the place of the doctor in the world. That is the doctor's identity as a doctor is sustained by the existence of patients.

In doctors' accounts of consultations the methods by which features of the doctors' identity are validated are apparent. Primarily this occurs through interpretations of patients' speech, but also through interpretations of patients' actions. For example the notion of being a personal doctor relies on a relationship between doctor and patient being maintained over time. When being a personal doctor was an important trait in a doctor's identity, it was validated not merely by patients returning to see them, but by the doctor's perception that they had actively chosen to do so.

"She had seen a number of the GPs in the practice relating to her miscarriages. What I found satisfying about it was that she had chosen – this is showing all my insecurity- but she'd chosen to come back and see me." (GP6)

Again using the example of regarding the self as a personal doctor, this was validated through the interaction between a doctor and certain patients with whom they had a long-term relationship.

In order for identity to be maintained it is often not sufficient to recognise consistent attributes and characteristics in yourself, these need external corroboration. This corroboration often arises out of interaction. For example this doctor is talking about a consultation with a young couple having difficulty conceiving. She attributes to herself characteristics that she believes are important in helping patients with infertility and she has these validated by the patient who had had experience of doctors elsewhere.

“I think I’ve got a little insight into the – not that we’ve been infertility patients – but into the waiting for a pregnancy, the anticipation, the disappointment and that kind of thing so I think I can empathise quite well with people in that situation....and I think from the psychological point of view if you can show yourself to be quite sort of warm and understanding then you can make a huge difference and I think that people with infertility problems who feel that their GP doesn’t care will have a much harder time. He said how different it was here, he’d already picked up the feeling it was different here which was nice.” (GP8)

Validation of identity by the patient in this way is an overt process in which the patient clearly expresses an opinion about the doctor and their practice. More commonly validation is less transparent. For example this doctor says of his encounter with an elderly male patient,

“The other thing about what made me feel good about that consultation was the fact that I knew that this guy was feeling good himself. And I knew that he was going out feeling that he trusted me, that he had a good doctor who was doing as much as he could for him and he was getting everything he would expect from a GP. And I knew that having been to see me would have had a good effect on him and that he would go home thinking ‘Right I feel happier’.” (GP1)

Here the doctor's self-identity as a good doctor was validated because he perceived it was recognised by a significant other. This perception was intersubjectively constructed in the interaction between the two of them and was not the result of a candid exchange of views about each other. Here the doctor had presented himself to the patient in such a way as to control his impression of him. This is not an attempt to deceive the patient but a way of sustaining his self-conception.

However identification by others has consequences. In the context of a doctor-patient interaction, being accorded particular characteristics by a patient is accompanied by assumptions about what the doctor knows, and what he will be able to do. When these assumptions are incorrect it is inevitable that the interaction is dysfunctional. Here, the doctor is talking about a dissatisfying consultation with an elderly lady with constipation.

"I think it almost was (OK). With very little effort on my part it could have been a very easy consultation and that's what irritated me. Again it was a relationship thing. Somebody who only sees me and who feels I am her doctor, well that's my impression anyway. She feels I know everything about her but I didn't feel I was living up to that. I felt I was conning her." (GP13)

It is clear that he felt his actions failed to substantiate her identification of him. And even though he was aware this identification was erroneous, he felt obliged to try to live up to it by putting on a performance to sustain some sort of reality of him as "her doctor". He is able to preserve a distinction between this performance and his self-identity but nevertheless the lack of authenticity leads to disappointment.

Hence the extent to which the performance in the consultation is one that is perceived as being "true to oneself" is important in maintaining identity.

Less experienced doctors are more obviously in the process of constructing and maintaining their social identity than more experienced doctors. Not surprisingly younger, less experienced doctors seemed to reveal more fragile identities. Whilst early experience might have served to construct and maintain certain aspects of their identity, this identity has not yet been stabilised. The identity is fragile because the biography the individual reflexively holds in mind is only one interpretation, among many other possible interpretations, of the events that constitute it. The collective component of it is, in comparison, relatively robust. As a result to some extent the identities of inexperienced doctors are precarious and liable to be challenged by the experience of consultations which might make other interpretations of past events more persuasive. The more precarious an identity, the more readily it is challenged and modified. The view of this doctor who had been a general practitioner for 2 years is typical.

"I'm probably at a stage in my career when I'm still quite sensitive to the popularity sort of factor and particularly in this practice where the standard of GPs, I think, is very high and there are certain very popular GPs and that is very obvious if you just look at the appointment book and ...maybe when I'm 20 years older I won't give a damn." (GP6)

Stabilisation of his identity requires repeated validation from the patient population as a whole.

Constructing identity

Repeated validation occurs as part of a wider identity building process. Younger doctors in particular have aspirations about the social identity they wish to develop. This process involves perceived areas of weakness being modified in interaction.

For example this doctor talks about how each consultation tempers his own view of himself.

“Then again this is true of a lot of consultations when I was thinking about it, that I recognise in myself that I’m not one of those natural people- that some of my partners are- that instinctively remember little details about patients. I mean down from their name to the face, to how many children they have, what they do, where they go on holiday sort of thing. Some doctors, some people have an innate talent for it, I don’t feel I have that. So it gives me satisfaction if I can draw on some of the past, the knowledge of the past that I have. And conversely if I get something wrong you know what job they do or that they’ve got ten children when they’ve got one. Well that irritates and I feel that should be part of my job and I find it difficult.” (GP6)

He alludes to a process whereby previous consultations have led him to ascribe to himself a certain social identity which is being challenged and modified in the light of more recent interactions.

Resisting challenge

In contrast, more experienced doctors tend to have more stabilised identities. Events in consultations are less likely to rupture their sense of self. As a result stabilised identities are resilient when challenged and are not terribly amenable to modification. The data suggests more experienced doctors hold quite strongly to typifications of themselves which enables them to withstand challenges to their identity. Identity is maintained by retrospective interpretation of the experience of the consultation. Experiences that have not met expectations are interrogated and mitigating reasons are found which allow the doctor’s self-identity to remain intact. Negatively evaluating the patient is one strategy used to refute challenge to the doctor’s identity. This doctor, who generally regards himself as an excellent

communicator, says of a patient with whom he has been unable to reach agreement,

"I'm sure he's impossible because I've tried everything I know and as far as I know another GP who I respect a great deal booted him off her list because she found him impossible to the point of where she lost tolerance with him, and we're talking about someone who doesn't do that very often. As far as I know every doctor he has ever met has come to the same conclusion." (GP16)

He also appeals to similarity with other doctors to refute the challenge to his individual identity. Furthermore the limits of medicine and the medical profession generally are also invoked to explain his failure and preserve his identity.

"And it might be because of what was done to him in the past. I think it's very important right from the start not to push people into this somatising. He has blackouts and he's had CT scans, he's had x-rays and he's had EEGs and he's had weird and wonderful cardiac catheterisations and he's even had a pacemaker put in because the cardiologists got so pissed off with him that they said 'we'll put a pacemaker in, if that works brilliant, if it doesn't you've obviously nothing the matter with your heart'. And he came to me yesterday to say he now wanted referral to a rheumatologist because he's decided it's his neck that's causing him to have blackouts." (GP16)

The limits of medicine were often used in accounts to defend doctors' self-identity as good doctors. The negative impact of context upon the interaction was also commonly used to maintain self-identity. This doctor has previously ascribed to herself an identity as a doctor that accords particular importance to sharing understandings with patients. In this consultation she describes failure to achieve this but resists the challenge this presents to her identity by citing contextual difficulties.

"Possibly if I'd had more time I think there might have been...I was running terribly late and that may well have influenced me as well. The fact that by that time I was running late I didn't really have time to explore things and that sort of added to my disgruntled feelings" (GP4)

Emotive responses to consultations

Considering the consultation as social action implicated in sustaining practitioners' identities provides a further dimension to understanding their emotive responses to consultations. As well as seeing these responses as the product of evaluative processes focused either on the patient or on themselves, they can be understood also in terms of the threat they pose to their own world view.

Consultations that were implicated in sustaining the coherence of the doctor's self-narrative were more likely to be experienced positively by practitioners than consultations that presented a threat to that narrative. In particular satisfying consultations were more likely to be those where integration into the doctor's self-narrative was seamless and where identity work was straightforward. Consultations that required the doctor to engage in more onerous identity work to resist challenge were more commonly felt to be dissatisfying. Consultations that doctors were unable to integrate into their self-narrative were among the most dissatisfying.

Conclusion

The consultation in general practice can be seen as part of an iterative process through which identity is attributed and consented to. Doctors take into every consultation self-understanding manifest as self-identity. This identity is crucial in the experience of the consultation because it influences the expectations the doctor has of themselves in terms of their performance within the consultation and encompasses the values that act as the wellspring for action within the consultation. Furthermore the experience of the consultation opens up self-attributed identity to scrutiny and potential maintenance, modification or

challenge by the experience of the consultation. Thus for the doctor the consultation is part of an ongoing process of identity building and rebuilding. Through this process they construct and sustain a reality of “who they are” in a professional sense which allows them to meaningfully experience their work. This process involves reflexive re-constitutive work that involves finding explanations for unsatisfactory experiences which distance themselves from the source or cause of the frustration. These explanations often involve invoking evaluations of patients such as those described and discussed in chapter 5. Therefore these moral evaluations of patients not only represent the way in which doctors have come to know them, but also are an integral part of the way doctors come to know themselves.

Summary

In this chapter I have explored how a doctor’s self-understanding or self-identity influences their experience of consultations and their accounts of that experience. I have suggested that what a doctor knows about himself or herself as a doctor is the result of retrospection and reflection upon the multitudinous experiences that constitute their working lives. A sense of self was rooted within doctors’ accounts of the experience of consultations, and the analysis of the interview data presented here reveals that doctors’ self-identity appears to have both collective and individual components. This reflects the autonomous nature of much of general practitioners’ work where there is individual legal, moral and ethical responsibility but also recognises that this is anchored within a powerful set of professional norms.

In this chapter the subjective meaning of consultations for doctors as events in their individual biographies was explored. Doctors’ self-identity was seen to impact

upon their expectations of themselves in subsequent encounters and to underlie their motivations in consultations. Furthermore their consultations, and their accounts of consultations, constituted social processes through which doctors were able to undertake identity work. This included work to maintain their membership of the group "general practitioners" and also to construct and maintain their individual identity. Identity was seen to be constructed and maintained by a process of validation within the consultation. The congruence of doctors' experience in consultations with their self-attributed identity is crucial to their expressions of satisfaction or dissatisfaction with consultations. Challenge to self-identity was perceived as present in some consultations and was resisted by doctors in their accounts through discursive strategies that separated the doctor (and their identity) from the source of challenge. Common strategies included negatively evaluating the patient and invoking contextual difficulties in the consultation in particular lack of time.

CHAPTER 8: CONCLUSION – DISCUSSION AND IMPLICATIONS OF THE STUDY

Introduction

In this final chapter I intend to draw together the findings of the study that I have presented in the preceding four chapters. I will then go on to discuss some possible implications of these findings for health policy and for patients using the health service, for medical education, for the profession of general practice, and for primary care research.

This thesis set out to examine how general practitioners experience satisfaction in their routine consultations with patients. The motivation for the thesis was a paradoxical observation that despite unremitting reports of poor morale, untenable workload, burnout and stress among general practitioners, there was little evidence of consensus among doctors about the necessity for, or prospective nature of, wholesale change to working practices. Thus the question is raised of what it is in their work that doctors value.

The attempts to define the core activities and values of general medical practice that have been undertaken over the last 30 to 40 years have generally not taken as a starting point observations of what general practitioners *are* doing. Rather they have explored their core values as something of an abstraction. The purpose of these definitions has been to decide what the general practitioner *should* be doing and why. The relationship between these definitions and the experience of everyday work is therefore not straightforward. This study was concerned with those aspects of general practitioners' work that are manifest in their consultations with

individual patients - activities which still constitute the core of their work - rather than with general practitioners' work in its entirety.

Issues influencing the way the "reality" of the general practice consultation is perceived by doctors were highlighted in chapter 2, the background to the study and selective literature review. This chapter considered the literature about general medical practice and revealed the pre-eminence of the doctors' communicative actions and clinical activities in constituting the nature of the general practice consultation. The actions of the doctor in the consultation were seen to be problematic in terms of the accomplishment of technical activities, the development of a therapeutic relationship with the patient, and the generation of positive outcomes of consultations for patients. Much of this literature presupposes a view of the consultation as an objective phenomenon in which the feelings and emotions of the doctor are subsidiary to measurement of the processes and outcomes of care. This is perhaps not surprising in the current climate where political imperatives are around developing a patient-led health service within which doctors are expected to operate in accordance with clear clinical governance and accountability frameworks. However doctors' views and expectations of their work may not always coincide with these perspectives. Given the extent to which doctors invest in their work, the impact of such disagreement may not only lead to frustration for the doctor in individual consultations but cultivate within the profession as a whole a culture of disaffection and disillusion with their work. This is likely to have long term consequences for the quality of health care delivered to patients and for the health and wellbeing of the practitioner. This study has explored how doctors' experience satisfaction in their routine work in consultations.

What are the limitations of this thesis?

Like many qualitative studies this is a small study which is primarily descriptive rather than intensively theorised. Its limitations include those that are common to many qualitative studies and relate to issues of generalisability. The difficulties I encountered recruiting general practitioners to the study meant the eventual sample of general practitioners was not only small but was above all a convenience sample. Although it contains a group of general practitioners who have diverse characteristics, there are certain characteristics which are not represented at all within the sample, for example ethnicity other than white British, and working outside of Lothian. Furthermore the doctors shared a willingness to participate in this kind of research which might mean they have more in common with each other than with the rest of their colleagues in the general practitioner community. Indeed there was little in their accounts that hinted at the disillusionment customarily attributed to the profession.

Furthermore although the intention of the study was to explore general practitioners' satisfaction with routine everyday consultations, the extent to which the consultations included in the study were representative of the generality of consultations is open to debate. Patients declined consent to record their consultations on occasion. I have no way of systematically comparing the patients and consultations included in the study with those excluded. Anecdotally however patients declined to participate because they perceived the content of their consultations to be too personal or sensitive, and in consequence consultations of this nature are probably under-represented in the study.

However qualitative research is never generalisable in the way that quantitative research is through applying the findings from a representative sample to a wider general population. Qualitative research is generalisable through the development

of theory that can be empirically tested, therefore these shortcomings in the samples of doctors and consultations are not disabling of the research. The possibility of developing a theory of doctors' satisfaction with consultations based on the findings of this study is pursued later in this chapter.

Recapitulation of findings

Before going on to advance a theory of practitioner satisfaction I will recapitulate the empirical findings of this study that underlie the theory I intend to propose. Notwithstanding its limitations the findings of this thesis have contributed to improved understanding of the meaning of everyday work for general practitioners. Four primary themes underpinning doctors' experience of their work including their satisfaction have been reported:

- the evaluation the doctor makes of his technical performance in the consultation (good or bad doctor);
- the evaluation he makes of the patient (good or bad patient);
- the sense he has of knowing the patient (the patient's way of being) and;
- the sense he has of knowing himself and of his self-identity.

Within these themes the centrality of relationships in constituting meaning in general practitioners' everyday work appears to be confirmed. The relationship between doctor and patient is the most obvious and prominent of these relationships, but this study also reveals the importance of other relationships, specifically the relationship the doctor the professional has with the doctor the person, and his relationship with the discourse about practice. These relationships are contingent upon the system in which primary care operates in the United Kingdom.

Relationship with patient

I will consider the doctor's relationship with the patient first. Medical disciplines other than general practice tend to define themselves in terms of the content of their work: in particular the common presentations and diseases they encounter and the technologies they use to address them. This content mediates the relationship between doctor and patient. In contrast, in general practice the content of individual consultations is mediated by the relationship between doctor and patient. This is because in most instances the relationship exists before the content of the consultation is known. In other words the relationship shapes the content of the work. In many ways therefore the doctor-patient relationship in the general practice consultation is the discipline's theoretical core. However the ambiguity with which this is viewed by general practitioners is clear in this study. The ongoing doctor-patient relationship is central to many positive experiences in the consultations yet in a small but significant number of situations, it is at the root of much dissatisfaction and in some cases potential harm. These cases are few but not exceptional. The relationship between the doctor and the patient is at the root of the moral evaluations that doctors make of patients. As I discussed in chapter 5, these evaluations are not objective but are produced in interaction between the doctor and patient and are used by doctors to explain and determine the course of the consultation. In other words the patient alone is not capable of determining and defining the doctor's experience of the consultation, rather this experience is the result of engagement between the individual biography and circumstance of both patient and doctor. Engagement between the subjective stories of doctor and patient can enhance the therapeutic potential of the consultation. Failure of engagement can, alternatively, lead to dissipation of therapeutic potential and the consequent maintenance of unhelpful behaviours and illness.

The relationship between patient and doctor in the consultation relies upon the patient and the doctor being in some way known to each other. In the interpretation of the data in this study a distinction was drawn between the doctor having knowledge about a patient and the doctor experiencing a sense of knowing the patient. In terms of doctors' experiences of consultations a feeling of knowing the patient, rather than having knowledge about the patient was important in maximising their satisfaction. A feeling of knowing the patient seems to be accomplished through an inductive, rather than deductive mode of reasoning about the patient which allows the doctor to understand the patient as an experiencing individual rather than a clinical case.

Relationship with self

The relationship between the doctor as general practitioner and as person also emerged as important in the experience of satisfaction in consultations. This relationship emphasises that the consultation is an event that needs to be incorporated into a doctor's personal biography. It also highlights the moral ambiguity that doctors sometimes experience in relation to their work. Adherence to a set of standards defines competence in clinical and communicative action and competent practice is a moral imperative. In Chapter 4 I demonstrated how practitioners have expectations of their performance within consultations. Doctors want and need to be perceived as "good". Indeed being a "good doctor" is an integral facet of doctors' self-identity. From a theoretical perspective the concept of identity can be used to help understand doctors' affective responses to the experience of consultations. Consultations in which doctors' self-attribution of identity was maintained were generally more satisfying than those in which their identity was challenged. Indeed in some instances the circumstances and context of some consultations conspired to threaten their right to claim moral goodness.

Doctors' accounts of the experience of such consultations are part of a process of bracketing out of certain aspects of the experience in order not only to explain dissatisfying consultations but also to maintain a positive self-identity. Dissatisfying consultations often require doctors to do *identity work* to maintain their self-conception as competent practitioners. This involves finding explanations for unsatisfactory experiences by which they separate themselves from the source of their frustration.

Relationship with the discourse about practice

As I have said doctors expect that they will be able to demonstrate competence in the technical aspects of their work. These aspects are defined in relation to the discourse about medical practice. This discourse forms the basis of the ideological expectations that underlie practice. The fact that such aspects are so prominent in the ways that doctors account for their experiences in consultations reveals the extent to which institutional reflexivity has contributed to the evaluations they have made. The relationship the doctor enjoys with the discourse about general medical practice is however not straightforward. Doctors seem at times to be rapt by the ideology and rhetoric, such that they seem to have no other way of accounting for their work, even those historically implicit aspects of their work. Armstrong makes a similar point in discussing the fabrication of nurse-patient relationships ¹⁹⁰ when he says that the way a problem is constituted in research may come to dominate the way that it is thought about more widely. On the other hand however in the present study there remains evidence of dissonance between the rhetoric of practice and the exigencies of everyday practice. For example holistic practice is an aspiration for some doctors but they rarely perceive they achieve it within the time constraints of routine work.

Synthesis of findings: towards a theory of practitioner satisfaction.

The findings of this study have identified individual constituents of doctors' satisfaction with their consultations. Some of these constituents are amenable to modification, for example their satisfaction with the technical aspects of their communicative and clinical action. Others are less obviously open to straightforward change, for example their knowledge of themselves "as doctor". Although these constituents have been identified across the doctors in this study, their expression is variable. The variability is due to the individuality of both doctor and patient and their influence upon each other in the consultation.

Furthermore although the findings of this study have been categorised discretely and presented in a linear order, it is clear that they are in fact inter-related and inter-dependent. For example there is significant interplay between doctors' moral evaluation of patients and their evaluation of their own performance in consultations. The moral evaluation of the patient provides a context for the implicit moral evaluation of themselves which underlies their appraisal of their performance. Similarly doctors' knowledge of themselves and their sense of self-identity are entwined with ideas about themselves as competent doctors. Therefore it is the interplay between the various elements of doctors' responses to consultations, rather than any single element alone that is important in determining doctors' overall experience of satisfaction in consultations.

In this study I did not set out with a conceptual model of satisfaction^{xx}. I sought to reveal how satisfaction was experienced by practitioners, and in doing so to

^{xx} Satisfaction is usually conceptualised as an attitude¹⁹⁹. It is the evaluation of the favourableness of the object of scrutiny and/or the affective response to it. Satisfaction is an evaluative concept in which the object in this case the general practice consultation, is appraised in terms of how expectations about it are met or in terms of the value of the activities accomplished within it.

understand something of how practitioners experience meaning in their work.

However the constituents of doctor satisfaction with consultations identified in this study allow conceptualisation of satisfaction for doctors in consultations in general practice. As a concept doctor satisfaction appears to have both cognitive and affective components. The cognitive component involves a process in which the doctor compares the activities of the consultation and his perception of the outcome of the consultation against a standard. This standard is different for different consultations but incorporates expectations of both the doctor's behaviour and the patient's behaviour within the consultation. The standard has two elements: one which defines general expectations of doctors and patients in this setting which is underpinned by an assumption of the moral goodness of both doctors and patients, and a second which circumscribes specific expectations for this encounter based on past experiences. For example knowledge and beliefs about a patient prior to an encounter play a significant role in determining subsequent evaluations of patients irrespective of what he or she actually did or was perceived to have done in the consultation.

The affective component relates to how the experience of the consultation for the doctor relates to a subjective sense of personal knowing of both the patient and themselves. The emotive response conveys the congruence between the experience and the doctor's sense of self-identity and his understanding of the patient's sense of being.

This two component concept provides the basis for a putative theory of doctor satisfaction with their consultations. The theory is underpinned by evaluative practices that incorporate the different psychological and social processes that have been elucidated in the findings chapters of this thesis. In this theory the satisfaction that doctors experience with their consultations is the result of both

cognitive and affective evaluations of their relationship with the patient, their relationship with themselves, and their relationship to the discourse about practice. Evaluation in the cognitive component is rational whereas evaluation in the affective component is intuitive. Expressions of dissatisfaction or satisfaction depend upon the individual doctor and the specific nature of the consultation in question. Positive evaluations in both cognitive and affective components should lead to maximally satisfying consultations. However the weighting given to evaluations in each of the components and the interplay between them is specific to each individual doctor in each consultation. Satisfaction for the doctor in any consultation is therefore no more of an objective phenomenon than the consultation itself.

The empirical findings of this study have alluded to the psychological and social processes underpinning the cognitive and affective evaluations made by doctors. It seems that doctors monitor both their activities in consultations and the circumstances surrounding them as a feature of their everyday work. Their accounts of consultations in interviews can be seen as discursive manifestations of this monitoring in which they provide explanations for and interpretations of their behaviour. In this monitoring process they appear to bring to bear their knowledge about the ideology of general medical practice, clinical medicine, human behaviour and much more. Furthermore this process is a conscious one which hints at the inherent institutional reflexivity of medical practice. It is partly through this monitoring process that new knowledge or information is incorporated into the setting of general medical practice or the general practice consultation. Such integration means the setting and activities within general medical practice are susceptible to chronic revision and that this new knowledge and information is not incidental to general medical practice in the late 20th and early 21st centuries but rather constitutive of it. Generally writings are an important part of institutional

reflexivity in that they serve to organise and, in some respects, to alter those aspects of social life that they report on. To a large extent the various writings about the general practice consultation seem to have organised and in some respects altered the nature of the consultation. For example in this study it was clear that the work about patient-centredness in the consultation has been crucial in formulating how it has become appropriate to account for the nature of general medical consultations. In chapter 4 doctors' accounts of communicative action within the consultation were routinely referential to the tenets of patient-centred clinical method, in particular reaching a shared understanding of the patient's problem. Furthermore monitoring of their consultations in this way means that their behaviour within them is susceptible to revision. It seems likely that doctors who monitor their consultations in respect of certain activities, for example patient-centredness, will change their behaviour to incorporate those activities into their routine work.

However the knowledgeability of doctors is not confined to discursive awareness of the conditions of their behaviour in consultations. This study indicates that much of the knowledge of doctors is not "held in mind" during consultations but is tacit and taken for granted. This knowledge relates to the social conventions of doctors' interchanges with patients, to their engagement with the system of the National Health Service and to the consequent constitution of their roles and responsibilities. This knowledge is incorporated into their daily practice at a non-conscious level and importantly provides a sense of continuity and order in everyday activities. This involves both doctor and patient behaving in a predictable and acceptable way. Monitoring of these non-conscious actions and behaviours also occurs, although not in a systematic way. What makes such behaviour appropriate is a shared framework of reality. In many consultations this shared framework is taken for granted and presumes an implicit acceptance of the identity

of both doctor and patient. When such a framework either does not exist or is contravened, cognitive and emotional disturbance can ensue. Moreover, in this study, when doctors were dissatisfied or frustrated in consultations, they often invoked perceived inadequacies in the patient's identity to explain their emotions, (chapter 5) or looked for reasons outside themselves to justify their own behaviour when this was perceived as inappropriate (chapter 7). Such discursive strategies helped them sustain a sense of order in their everyday work.

Satisfying consultations were in effect predicated on sustaining this taken for granted sense of continuity and order, even though this is difficult for respondents to put into words. A resultant sense of "ontological security" lies at the heart of doctors' positive affective responses to consultations. However beyond this a sense of productive involvement with individual patients is fundamental to the most satisfying experiences. A productive sense of involvement for doctors generally requires that they perceive therapeutic utility from their actions, and that they know the patient and that their actions reflect a coherent sense of their own being. Doctors often found it easier to account for consultations they found dissatisfying than for those they found satisfying. Dissatisfying consultations brought to mind some of the actions and behaviours that were otherwise non-conscious, and doctors reflected upon them and found within them ways of accounting for their experiences.

Implications

Implications of this study for health policy and for patients using the health service

Many of the dissatisfying elements of the experience of consultations reported in this study seem to be related to aspects of the present health care system. At the same time the organisational characteristics of the present system seem to underpin much of what it is that doctors value in their work. Such dissonance is a challenge for professional leaders and policy makers alike.

The potential of the health care system to shape the relationships between doctors and patients is important, and should not be underestimated in considerations of the future of the health service. The structural features of primary care in the United Kingdom, for example a registered patient list, have been instrumental in determining the character of the doctor-patient relationship in general practice. Furthermore I have shown how over the last 40 years of the 20th century the role of the doctor in the general medical consultation changed in response to transformations in the political identity of the patient. That doctors continue to ascribe to this role is a testament to the collective institutional reflexivity of the profession. The beginning of the 21st century is however a time of insistent and conspicuous questioning of the fundamental virtue of the present health care system, or at least of its capacity to deliver the care needed or demanded by patients. Developments in the health care system in the United Kingdom over the last 10 years have already led to fragmentation of care. Out of hours primary care is now generally not provided by the patient's general practitioner or his partners, acute care can be accessed through nurse-led walk-in clinics in shopping centres, and advice is available 24 hours a day from telephone help-lines. The contractual

arrangements for general practitioners are also currently under review. These service changes are occurring against a background of advances in information technology, telemedicine, new genetics and clinical science. This changing system will shape the relationship between doctor and patient in the future.

One risk is that clinical care in the future will become “fully industrialised”¹⁹¹ and essentially episodic. What we think of now in general practice as a relationship, which has meaning to both patients and to doctors in terms of their individual biographies, will become a sequence of, at best, loosely connected experiences whose relation each to the other is neither clear nor intentional. Evolution in health care and its delivery is inevitable but evolution in primary care should not occur involuntarily without due regard for the tensions it is likely to provoke in individual practitioners. This study has amply demonstrated that meaning in consultations for doctors lies beyond the checklist interrogation of communicative and clinical action. Meaning lies in the consultation as an event in the biography of both patient and doctor. Changes that dislocate this link are likely to lead to an increasingly disengaged and disenchanted profession and possibly to an increasingly dissatisfied patient population. Indeed with its emphasis on standardised clinical care as a means to improving population rather than individual health, and on clinical effectiveness (as opposed to interpersonal effectiveness) as the benchmark of quality of care in general practice, the new general practice contract may actually compound rather than alleviate poor morale. In fact such a detrimental effect seems inevitable unless any loss of what is meaningful to practitioners in their work is replaced with an equally rewarding alternative. This study provides little evidence to suggest the proposed new contract will offer such opportunities.

Implications for medical education

Much of undergraduate medical education is based on the premise that the reality of illness and disease can be discovered through the use of scientific method. And that once this is known technologies can be applied to treat the illness and disease. In this model knowledge is objective and unmediated by the mind of the investigator or the doctor. The practice of evidence based medicine is predicated on this view and has been incorporated into medical curricula as the “gold standard” of practice.

However the real problems and pleasures of practice revealed in this study are not those that require the application of technical biomedical or evidence based solutions but those where the experiences of the doctor and patient engage their emotions. In these situations the reality is fundamentally mediated by the minds of both doctor and patient. It is a subjective reality whose characteristics are constructed in interaction. This study suggests that doctors sometimes struggle to reconcile the objectivity of their education with the experiential knowledge born of their practice. The problem for general practitioners is that clinical teaching has inculcated them with scientific rationalism that suggests that the problems of the consultation should be amenable to medical intervention. When such intervention is not possible or is unsuccessful, the relationships within the consultation are scrutinised and found wanting, and dissatisfaction can ensue. In some respects such situations hint at the present limits in the practice of patient-centred medicine. This presents a real dilemma for medical educationalists. How to balance the inexorable trend towards objective rational practice with the need to equip students with the necessary attributes to survive in the “swampy lowlands” of everyday practice.

One potential way to address this problem is for medical education to explicitly promote the development of appropriate attitudes and values alongside the acquisition of necessary knowledge and skills. However at the present time neither a consensus about a blueprint of these attitudes and values, nor a clear vision of how to deliver medical training that promotes their development has emerged. Therefore ‘what is a good doctor?’ and ‘how do you make one?’ remain perennial questions. Toon calls for doctors to take a more interpretative, rather than mechanical, view of their role⁷⁹ and argues for the necessity of virtue in good medical practice⁸³. He suggests that without virtue a technically competent doctor cannot be a good doctor. He describes ways in which medical education might cultivate virtue in doctors including habit training, modelling, cognitive-emotional methods and reflective practice. The idea that medical education should involve more than the acquisition of a value free body of knowledge and the skills to use it is commonly held. In a recent theme issue of the *British Medical Journal*¹⁹² the same questions of ‘what is a good doctor?’ and ‘how do you make one?’, were addressed. The published responses also alluded as much to desirable personal qualities, in particular respect for and appreciation of the patient’s perspective, as to the necessity of knowledge and proficiency in technical skills. However the need for doctors to be aware of the contradictions and incoherence of their own thoughts and feelings and to be able to reflect upon these was identified much less frequently. Yet the empirical findings of this thesis support Toon’s assertion that “emotions and cognitions are intimately related to each other and to our actions”⁸³ and suggest that good medical practice requires that doctors analyse their own thoughts, feelings, expectations and attributions. The proliferation of formal assessment criteria for professional competence suggests that such conscious reflection has been deemed an insufficiently robust process to guarantee professional goodness, however it seems clear that without it professional goodness is unlikely to be achieved.

An alternative interpretation of this state of affairs would suggest that doctors are inadequately educated to undertake this process of conscious reflection effectively. The knowledge, competencies and values to be demonstrated in order to gain a medical qualification in the United Kingdom are laid down in the General Medical Council's document 'Tomorrow's Doctors'⁹⁴. Since its publication in 1993 most undergraduate medical curricula in the UK have been re-designed to conform to its criteria. The expressed aims of undergraduate education in this document include the development of appropriate skills and attitudes for lifelong practice. In fact this has tended to be interpreted as the development of self-directed learning skills which can be utilised in lifelong learning, rather than the development of self-awareness for use in practice. Some undergraduate courses now include personal and professional development in their curriculum but even here the emphasis is on the development of appropriate professional attitudes rather than the explicit development of self-knowledge. In consequence undergraduate curricula still tend to neglect consideration and understanding of the doctors' emotional development and the related development of reflective capabilities.

The situation in postgraduate general practice training is conceivably worse. Having been at the forefront of moves to incorporate a wider vision of patients and their health into medical practice, registrar training is now burdened by the cult of accountability prevalent in many areas of public life. General practice registrars are trained to meet minimum technical standards in knowledge and consultation skills. The bottom line of training is passing summative assessment which involves acquisition and demonstration of appropriate communication skills within the consultation. Whilst some consider training in communication skills as a pre-requisite for the change in attitudes needed to be truly patient-centred, others recognise that of itself such training is insufficient to help doctors to deal with

patients' feelings and emotions. In their everyday working life many doctors have difficulty in applying in practice their newly acquired skills. In this study consultations were not wholly satisfying or dissatisfying to doctors because they were objective, rather those that engaged their feelings most strongly were more commonly deemed maximally satisfying or dissatisfying. The importance of knowing their patients to their satisfaction with consultations, which emerged in this study, confirms that generally general practitioners do not wish to be uninvolved with their patients. However this study has also shown that concern for patients as experiencing people has the potential to subject doctors to uncomfortable feelings such as a sense of ignorance, anxiety and helplessness. The experience of such negative emotions in some instances leads doctors to find it necessary to objectify the patient as revealed in chapter 5. This has the effect of separating the doctor from responsibility for his own emotions. This is unlikely to be helpful for either patient or doctor. As McWhinney says we can only attend to patients' feelings and emotions if we know our own¹⁹³. Self-knowledge is perhaps as neglected in post-graduate general practice training as it is in undergraduate medical education. In "Valuing General Practice"¹⁹⁴ the Royal College of General practitioners indicates the need for urgent reform of vocational training to take account of the complex skills required by a "modern" general practitioner in the context of developments in the health service. This plea is made in relation to the new technical tasks likely to be undertaken by general practitioners in the future. Reform of vocational training to enhance self-awareness is equally needed if general practitioners of the future are to lead maximally satisfying professional lives.

Others have called for medicine and general practice to become a self-reflective discipline^{193,195} in which the "knowing" and the "doing" are iterative. In other words the claims to knowledge and power arise from reflective experience rather than

from knowledge of abstractions. In much training and education however knowledge has been separated from experience, and thinking from feeling. Evidence based approaches to health care are favoured over anecdote. This study suggests that training for a satisfying professional life as a general practitioner needs to blend knowledge and thinking with experience and feeling. Only in this way will general practitioners of the future be able to address the complex and context bound problems of practice that currently engender unhelpful emotions.

Implications for the profession of general practice

The need for general practice to identify a sound knowledge base, and a discernible philosophy has been repeatedly espoused^{114,196}. This endeavour is considered important if general practice is to sustain claims to disciplinary identity and professional status. The empirical and conceptual writings about general practice of the last 50 years along with the development of coherent post-graduate training have done much to define general practice. However contending claims about the knowledge base of general medical practice exist because of the perceived disunity between the prescriptive ideals underpinning these writings and the everyday practice of doctors. As I have indicated much of the knowledge of general practitioners is implicit and consequently difficult to convey. General practitioners themselves recognise when those things, including values and attitudes, that are central to good general medical practice are threatened, yet often they cannot elucidate clearly why this is the case.

High profile cases in which concern about the standard of care provided by doctors has been evident have led to the need for doctors to demonstrate their fitness to practice. Periodic re-validation of doctors is being developed in order that the public can be assured that they are receiving a high standard of care from doctors.

The general practitioners' committee and the Royal College of General Practitioners have jointly produced a document setting out the standards of good medical practice for general practitioners that will inform the process of re-validation¹⁹⁷. It describes what is expected of a general practitioner by detailing sets of criteria for the excellent and unacceptable general practitioner. Politically and socially imperative as re-validation is, it is nevertheless part of the relentless bureaucratisation of general practice work which risks denying the real nature of general medical practice because of the invisibility of much of the important work. In "The Mystery of General Practice"⁸², Iona Heath argues that the general practitioner has two roles: one as interpreter and guardian at the interface between illness and disease, and a second as a witness to the experience of and search for meaning in both illness and disease. In this study a sense of knowing the patient was central to many of the doctors' most satisfying experiences. This incorporated an understanding of the patient's way of being which is fundamental to fulfilling these roles. We have also seen how institutionally reflexive the discipline of general practice has been over the last 40 years. The activities of re-validation are unlikely to stand outside practice and merely report upon it, and much more likely to be constitutive of it. General practitioners are socialised into the culturally and locally appropriate ways of looking at their practice and the pervasive influence of re-validation and accreditation could present a threat to the traditional values of practitioners. Likewise the new general medical services contract with its focus on measurement of the quality of clinical care for specific diseases could lead to re-definition of the role of general practitioners so that it becomes unrecognisable.

In "what is a good doctor and how do you make one"- the recent theme issue of the *British Medical Journal*¹⁹² - one respondent wrote:

“Jungians speak of the concept of the wounded healer: that clinicians must be aware of their own woundedness so patients can find the health in themselves. The relationship between the two of them becomes in itself a creative medium unique to that encounter. The protocol is a necessary, but enormously limited tool, which provides only the beginnings of good care. Real evidence based practice is fluid, ever changing and continually revisable specific knowledge. Some of the necessary knowledge is that which is created in the consulting room itself.” (p714)

This might be a statement of the core and distinguishing features of general medical practice. With its focus on the commitment of the doctor to the individual patient rather than to the person with a particular disease, and its integration of the subjectivity of the doctor into the therapeutic mix, it certainly embodies many of the attributes of a satisfying encounter revealed in this study. However newer definitions relating the key features of general medical practice focus on the core clinical and psychosocial competencies of the general practitioner and neglect the moral dimensions of the work.

The extent to which a general practitioner's work can be done by other health care professionals is an issue of prime importance to the profession. The development of guidelines for the management of chronic diseases such as asthma and diabetes has fuelled the development of the role of nurses in primary care. Further expansion of the role of nurses in primary care into the diagnosis and treatment of minor illness has followed. Such encroachment upon the traditional roles of general practitioners has been perceived by some as a threat to the status of general practitioners. The findings of this study do not appear to substantiate this threat. All these developments rely on a degree of clarity and certainty in patients' presentations, which is present only rarely. Following protocols for the diagnosis of minor conditions requires that symptoms are presented in a differentiated way which allows straightforward discrimination between one disease and another. Guidelines for management of acute and chronic conditions not only require that these conditions are appropriately defined but also that they are uncomplicated by

physical, psychological or social co-morbidity. In this study general practitioners appeared to value their determining role at the interface between disease and illness rather more than their role as manager of evident disease.

Changes in general practitioners' core values are inevitable along with changes in the demands of patients and the expectations of doctors from within the health service. Nevertheless service changes such as those imminent in the new general practice contract ought not to occur in spite of practitioners' core values. The values of the profession underpin all the key relationships in primary care. Indeed they are the consequence of a view of practice which prioritises the distress of patients, which cannot be measured, above the technical and measurable in diagnosis and treatment. Yet the pre-occupation with the technical and the measurable among policy makers has a number of possible consequences, the most telling of which may be further destruction of professional morale.

Implications for primary care research

This study has magnified the subjectivity of the doctor. In much primary care research this is neglected in favour of a view of the doctor as the embodiment of sets of knowledge and skills, which can be reliably and consistently applied. The emotions and relationships seen to be so important in this study are poorly addressed, if at all, in most research. It is therefore perhaps unsurprising that research rarely seems to attend to those issues of most importance to practitioners. At a time when regulation is seen as a way of influencing the behaviour of general practitioners and promoting "best practice", primary care research and its funding ought not to subscribe blindly to a technical biomedical model of care. To do so risks marginalising the interpersonal aspects of care seen to be so important to practitioners in this study. Rather primary care research

ought to embrace analysis of doctors' thoughts and feelings as crucial contexts in the provision of care, and as vital influences upon doctors' behaviour and its subsequent impact upon the patient.

Final comment

General practitioners' experience of satisfaction in consultations appears to be subjective and individualised. It is underpinned by the nature of the relationship they have with the individual patient, by the relationship between themselves as doctor and as person, and by the way they relate to the discourse about practice. These relationships are highly particularised and produced in interaction in their everyday work. Therefore the findings of this thesis have not produced a recipe for a satisfying consultation. Nor have they identified characteristics of doctors that lead to them being satisfied. Nevertheless changes in the organisation of health care that deny the subjective nature of much general practice work clearly risk both undermining the potential for satisfying work experiences and generating further disaffection among general practitioners. The potential implications of this are far reaching not only for doctors but also for patients and for the inefficient and ineffective use of resources.

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Knowing patients and knowledge about patients: evidence of modes of reasoning in the consultation?

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Background. The idea that the patient is in some way known to the doctor is an important one in general practice. The thrust towards patient-centred medicine, the promotion of open and negotiative consultation skills and the development of a biopsychosocial model of primary care medicine all rely on the patient providing a history composed of more than a list of facts.

Objective. Our aim was to explore the nature and importance of doctors' knowledge about patients.

Methods. Fifteen GPs audio-recorded 25–30 consultations with consecutive consenting patients. They scored each consultation according to how satisfying they found it. Semi-structured interviews based on a selection of consultations were conducted to draw out the doctor's views on the factors that were important to their satisfaction. The interviews were transcribed verbatim. Qualitative analysis was inductive and iterative.

Results. Within doctors' narratives, we found accounts of two ways of 'knowing' the patient. The first was a deductive mode of reasoning derived from facts about the patient. The facts that were known were specific to the context of the general practice consultation and led to bio-medical and biographical knowledge. The second was an inductive mode of reasoning derived from a contextual interpretation of the facts about the patient which resulted in knowledge of their behaviour and cognitions. Both modes of reasoning gave the doctor knowledge of the patient and permitted action by the doctor in the consultation but led to different interpretations of the patient and different experiences of the consultation.

Conclusion. 'Knowing the patient' is important to the way GPs attribute meaning to their work. Doctors were more likely to identify as 'known' those patients with whom they adopted an inductive mode of reasoning. In addition, their experience of the consultation was more likely to be positive.

Keywords. Consultation, GPs, 'knowing', knowledge.

Introduction

This study concerns a concept that is central to understanding the general practice consultation, but which is largely neglected in debates about it. The idea that the patient is in some way 'known' to the doctor is an important one in a professional discipline that has, through much of its recent history, placed great importance on the interpersonal relationship between doctor and patient and its operationalization within the consultation.

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The consultation: analytic approaches

Consultation analyses of different kinds have been crucial to the professional project in general practice. Since the 1960s, a significant literature has grown up that explores the dimensions of doctor–patient interaction in the consultation. From the very beginning this has involved attempts to describe the business of the consultation, often using research methods that isolate particular kinds of activity (verbal and otherwise) within it. Indeed, the literature on the doctor–patient encounter in the consultation seems to fall into four main categories.

- (i) Consideration of the doctor's work that interprets it from relatively abstract theoretical perspectives.^{1,2}

- (ii) Explorations of the doctor–patient encounter that emphasize power and knowledge relations in their social context.^{3–6}
- (iii) The sociology and psychology of the clinical encounter in relation to specific disease states.^{7,8}
- (iv) Consideration of the consultation in relation to clinical skills and technical problems of practice.^{9–11}

Although each of these approaches involves a very different interpretation of doctor–patient interaction, they are united by a recognition that the consultation is an encounter that relies on each participant being in some way ‘known’ to the other. At an elevated level, the attribution of (and consent to) particular social identities is crucial to this. At a more mundane level, both doctor and patient tend to have relatively stable expectations about each other’s behaviour in the consultation. One expectation that GPs have is that they can ‘know’ their patients. The thrust towards person-centred medicine, open and negotiative consultation skills and the biopsychosocial model in primary care medicine all rely on the notion that the patient will provide a ‘history’ composed of more than a brutal list of facts. Beyond this, British general practice is still run through with strong professional expectations about continuity of personal care¹² and the potential for long-standing therapeutic relationships. However, what it means to ‘know’ the patient depends on a good deal more than marshalling a particular set of facts. In fact, it derives from patterns of reasoning and interpretation. Here we explore those styles of reasoning about the patient as they are revealed through a qualitative study of GPs’ perspectives on those factors that lead to their satisfaction with the consultation.

The analysis offered herein takes as its starting point the doctor’s view of his or her medical work in the specific form it takes within consultations. It takes account of the diversity of work that is done in this context and therefore does not restrict itself to consideration of work with patients with specific diseases but examines the work done by practitioners with patients who have presented to them with various needs and expectations.

Subjects and methods

To examine the way in which GPs obtain satisfaction from consultations, a qualitative study was carried out involving indirect observation of consultations and semi-structured interviews with 15 GPs.

The doctors were recruited into the study following a personal telephone call from one of us (KF). The sample was purposive and, by design, diverse. Seven of the doctors were female; eight were male. They had been practising as GPs for between 2 and 22 years, and their ages ranged from 30 to 55 years. One doctor worked single-handedly, the rest worked in group practices with between three and nine doctors. Fourteen of the

15 doctors were partners in the practices in which they worked. The practices were in areas ranging from high socioeconomic disadvantage to affluence.

The participants were invited to audio-tape record between 25 and 30 consultations with consecutive consenting patients. They were asked to score each consultation according to how satisfying they found it on a scale of 0 to 10, where 0 was maximally dissatisfying and 10 maximally satisfying. The audio-tape recordings were reviewed and notes were made on the content of the two most satisfying, the two least satisfying and two other consultations chosen at random for each participant. These consultations formed the basis of a semi-structured interview conducted with each participant within 1 week of the completion of audio-recording. The purpose of the interviews was to clarify the details of the individual consultations and to draw out and discuss the doctors’ views on the factors and issues that were important in contributing to their satisfaction with the encounter. The interviews themselves were audio-tape recorded and transcribed verbatim.

The interpretation of qualitative data was governed by the broad precepts of constant comparative analysis.¹³ The interview transcripts were analysed iteratively (jointly by KF and CRM) to identify recurring themes within the data and recognizing patterned ways of accounting for the experience of consulting. The following discussion focuses on one major theme that emerged from the data: that of doctors *knowing* their patients.

Results

Knowing the patient

The doctors who were interviewed talked about their knowledge of the patient in the majority of the consultations that were examined. This knowledge seemed to be crucial to the way in which the doctor experienced the consultation. It was clear that in the majority of consultations, the doctor had *a priori* knowledge about the patient and that this knowledge took a very specific form shaped by the context within which it was acquired, i.e. the general practice consultation. Knowledge about the patient was generally related as biomedical knowledge or biographical knowledge including what McKeganey refers to as ‘ethnographic’ knowledge.¹⁴

However, the perception of ‘knowing’ the patient is not necessarily predicated on this knowledge. A lot can be known about a patient without the doctor feeling that he ‘knows’ that patient and, conversely, patients about whom little is known can be considered as ‘known’. Thus a distinction emerged between what was known *about* the patient and knowing the patient as a person. Furthermore, in terms of the doctor’s *experience* of consultations, the facts that are known about patients seem less important than the way in which the facts become known to them or the way in which doctors get to know about individual patients.

The remainder of this paper explores the ways in which doctors get to know about their patients and the different types of knowledge that result. The impact of these processes and this knowledge upon the conduct of the consultation and upon the doctors' experience of the consultation will be discussed.

Deductive and inductive knowledge about the patient

Within doctors' narratives about the experience of the consultation, accounts of two ways of 'knowing' the patient were apparent.

- (i) Knowledge of the patient that is founded upon a deductive approach, i.e. the doctor formulates a hypothesis about the patient based upon initial factual evidence of different kinds, and then seeks to confirm or refute this by a line of questioning that obtains further information from the patient.
- (ii) Knowledge of the patient that arises from an inductive approach to the patient's own account. In this case, despite *a priori* factual knowledge, the doctor does not hypothesize about the patient but allows an interpretation of the patient to emerge within their interaction.

A deductive mode of reasoning about the patient results in the doctor focusing on factual or objective information, either directly from the patient or from medical records. Whilst this information is often provided willingly by the patient, it is not divulged spontaneously. The patient grants the doctor access to this information because it is requested and believes it to be important to the conduct of the consultation. As a result, the doctor gains a set of unilaterally worked up facts—medically oriented knowledge about the patient—but their interpretation is not necessarily shared with or by the patient. For example, this doctor is talking about a patient whom he sees very frequently with self-limiting physical symptoms.

"I don't mind holding on and I don't mind having superficially dysfunctional consultations with people if I can continue with them long enough to work it out. And that has helped with her, it has worked with her a little. There have been a few consultations when having seen her for 2 years I am able to talk to her about her bereavements, her turning forty and her inability to have children which are her big problems. and that has possibly helped a little." GP1

Similarly, this doctor about a middle-aged man with ongoing low mood:

"So it's trying to find out what goes on in their life, and again another advantage of being in general practice, particularly in a fairly tight community like this, is you can understand a lot about where they live, who they live with and who they interact with,

both in terms of their family, extended family and friends . . ." GP11

In both instances, the GP talks about 'facts' in the context of the patient's life, and about the interpretative function through which he attributes meaning to the facts constructed in history taking. The interpretation is his own and it is not clear how this relates to the patient's interpretation. As a result, the doctor has unilateral knowledge of the patient within the specific context in which he is presenting, and here this is characterized in terms of an absence of connection.

"Well it would be interesting to know what he thought actually, because he's definitely the kind of bloke that you know he seems to leave the room quite happy but you've no idea what he's thinking, certainly not on my wavelength." GP7

An inductive mode of reasoning in the consultation involves a jointly produced account of the patient's ill-health and the doctor's response. Here, the patient voluntarily admits the doctor into the inter-subjective construction of information perceived to be relevant to her ill-health.

"That was the third one (consultation) that she'd been to and the first two consultations she just sat and cried for the first sort of five minutes and been in such an almost hysterical state that she'd been barely able to get her words out and she'd had these dreadful social problems—they'd moved down from X, they'd been kicked out of their house and discovered they'd bought a car which turned out to be stolen property and they got arrested and held by the police and it was just a whole string of disasters and the first time she came to see me . . . I mean I just felt like weeping when she finished telling me the story herself. I just thought you know how bad is it going to get for this girl, she was just a mess and there was a lot of ignorance about the hepatitis C business . . ." GP8

The doctor has few preconceived ideas about what information is needed or relevant but allows the salient issues to emerge from the interaction. Furthermore, the meaning of these issues is constructed jointly by both doctor and patient. Thus, the doctor gains a 'voluntary' knowledge of the patient which allows a shared understanding of the patient and the doctor-patient relationship to develop.

When doctors felt they knew a patient in this way, they often described a 'connection' or 'rapport' between themselves and the patient. This was associated with an ease of interaction which facilitated therapeutic aspects of their relationship. As this doctor says about a patient:

"I feel that we connect. We've met on quite a few occasions and I feel easy talking to her and I'd like to think she's found it reasonably easy to talk to me.

She's had some psychological difficulties related to her physical problems and I've sort of, I hope, helped her with that and drawn some of that out of her which I think maybe she wouldn't have talked to some of the other doctors she didn't know so well." GP6

Consultations in which doctors perceived a 'connection' between themselves and the patient were by and large among the most satisfying.

Impact on consultation: the concept of meaningful knowledge

In any consultation, some knowledge of the patient is obligatory for the doctor to be able to proceed with his work. Reasoning of either of the types described above can give rise to this obligatory knowledge, but each results in different interpretations of the patient. Deductive reasoning tends to lead to an interpretation of the patient as a case, whereas inductive reasoning is more likely to result in knowing the patient as an 'actor' in a social interaction. These different interpretations influence the subsequent course of the consultation and underpin the actions that are taken.

When a deductive mode of reasoning is foremost with a patient, the action that is taken is determined primarily by a reading of the facts of the case. Consequently, it is difficult for the doctor to predict the outcome of the consultation in the patient's 'world'. This doctor is talking about a patient who presented with a possible small haemoptysis

"And you always like when you've had a consultation to have an idea what the patient will be thinking of as they go home and when they get home what they will tell their family, and I have absolutely no idea what that lady thought. Maybe I didn't use any of the right words or whatever, I don't know, I think I maybe tried to but I have no idea. And when she came back again I really had very little idea of what she was thinking. And we rely on feedback, of course we do, to let us know if we're doing OK." GP2

When an inductive mode of reasoning is pre-eminent with an individual patient, the facts the doctor knows about the patient are understood within the context of the patient's life, making meaningful action possible. Here, an interpretation of factual knowledge within the patient's world permits the doctor to act in partnership with the patient to individualize the therapeutic intervention.

"Even with a fellow like that who had certainly had a depressive illness and he's probably passed that now, his major problems lie in his confidence about his own self and finding a direction. He's going through a kind of midlife crisis, because he's this age, he's single, he's wanted a wife, he's wanted children,

and he feels he's well passed all of that stuff now. So you're trying to find ways of him coping with that bit of life that he's in at the moment, which aren't hard psychology—behavioural cognitive stuff—but neither are they about taking tablets and this will make you better. So it's trying to find ways that suit him as an individual to get better." GP11

Furthermore, the consequences of the consultation in the patient's world become easier to predict, and this insight contributes to the doctor's positive feelings about the consultation.

"The other thing that made me feel good about that consultation was the fact that I knew this guy was feeling good himself, and I knew that he was going out feeling that he trusted me, that he had a good doctor who was doing as much as he could for him and he was getting everything he would expect from a GP and I knew that having been to see me would have had a good effect on him and that he would go home thinking 'Right I feel happier'." GP1

The doctor's own subjectivity is highlighted in consultations with patients in whom inductive reasoning is paramount. The doctor's action may deviate from what might be expected after an objective appraisal of the facts of the case and based on information from diagnostic technologies. Their interactions with the patient and experiences allow them to exercise discretion about what should be done or not done. As this doctor says:

"I think probably when I was younger I used to fret about that and wonder 'gosh am I doing the right thing, am I going to harm someone' but I think what I do now is I tend to let things drift a little bit and in that drifting period sound out the patient as to what they would feel about changes . . . and then you know that the patient's with you." GP7

"I think despite the fact that we might not have done the *right* thing with her, I don't know that that probably mattered all that much because she's the type of patient . . . if they like you it makes you feel better and I think she probably likes me and I know she appreciates what I do and respects me." GP10

Deductive and inductive knowledge are not mutually exclusive. Doctors are able to have, and often do have, both types of knowledge about patients, and indeed each type of knowledge can complement the other. For example, this doctor says:

"She's just brilliant. She is just an amazing woman. The first letter in her case notes volume one says 'This blond vivacious and attractive woman presented to me.' That's the same woman and if you read through what's happened to her in her life, she's had an abusive relationship, her mother was killed by a roadsweeper, her husband had alcohol

problems and was abusive and violent, her son was handicapped. And if you go through the catalogue of her life you know where she's coming from and it all makes sense when you see what's happened to her. But if you saw her as a one off you'd think she was a very mentally dull poor soul. But I think you have a rare insight into somebody's life and I completely understand why this lady's how she is. She's been to see somebody at the pain clinic nine times, nine separate referrals in the last 15 years for pain because she has a lot to gain by being ill." GP2

The way in which doctors understand a patient is instrumental in their evaluation of the moral status of the patient. This moral judgement seems to be an important factor in the calculation the doctor makes about the effort involved in working with a patient and the potential reward.

"I'm very controlled about that . . . I must make some judgements about the extent to which I think these people are helpable or actually want to change in some meaningful way, if they do I'll work with them, if they don't I'll freeze them out, probably politely but nevertheless freeze them out." GP12

Conclusion

The objective of this study was to understand better the sources of professional satisfaction with the consultation at a time when, as we have observed previously,¹⁵ interest in this topic focuses almost entirely on patients' views. The limits of the present study are clear, and it is important to note that we are drawing a set of inferences (second order constructs) from a body of qualitative data that was organized around experiences of the consultation, rather than patterns of reasoning within it. Nevertheless, the concept of knowing a patient is clearly important in the way GPs attribute meaning in their work. It is also potentially important conceptually because of how it might relate to the issue of continuity of care. The relationship is unlikely to be a straightforward one especially as more than one definition of continuity of care exists. However, in the context of general practice, personal continuity is usually privileged. This is generally regarded as occurring when the same doctor delivers care to one patient over an extended period of time. The assumption follows that care is then delivered in the context of an ongoing doctor-patient relationship and, in consequence, takes account of the patient's personal and social context. Reasoning of either of the types described here can lead to knowledge of this context; however, sensitivity to the unique meaning of this context in individual patients is much more likely to result from inductive reasoning.

Furthermore, if inductive reasoning about a patient occurs, discontinuity of care need not necessarily be a barrier to achieving this sensitivity.

In conclusion, when doctors perceive they have discerned the authentic nature of patients as human beings they denote these patients as 'known'. This feeling is most likely to materialize out of an inter-subjective construction of the doctor-patient relationship and allows doctors to get away from the need to objectify patients in biological, psychological or biographical terms.

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